BULLETIN of the MENNINGER CLINIC

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BULLETIN of the
MENNINGER CLINIC

VOLUME 10 JANUARY, 1946 NUMBER 1

THE MENNINGER FOUNDATION SCHOOL OF PSYCHIATRY

Introduction

In a previous number of this BULLETIN (March 1945) an attempt was made to survey the field of psychiatric education with the aim of noting some of the limitations and defects in the present system and suggesting certain objectives for the future. In the field of graduate training it was pointed out that the emphasis is changing from intramural psychiatry to extramural psychiatry and that consequently the teaching in hospital residencies is no longer adequate unless it includes this new orientation to out-patient problems and training in treatment techniques applicable to them. It was also argued that the resident in graduate training needs systematic didactic instruction, tutorial counsel, seminar participation, and reading prescription and guidance, all in addition to actual clinical experience. In such an intensive teaching program the resident can no longer "pay his way" by his work as a medical assistant. Since neither the hospitals nor the average resident can afford to pay the additional cost, the problem is how to provide well-rounded training.

With these considerations in mind, and with the pressure of many applicants for graduate training coming out of the Army and Navy, the Menninger Foundation decided to establish a graduate school of psychiatry which would incorporate the psychiatric services of a number of other facilities. Such an organization has the advantage of giving the student a varied experience on in-patient and out-patient services and at the same time of keeping him under the guidance of a central school and its faculty. His instruction is planned and correlated with his progression from one psychiatric service to another. The faculty employed by the School oversees the student's work in the various services and institutions to which he is assigned. The cooperation of several hospitals and agencies in this teaching program plus the educational provisions of the "G.I. Bill of Rights" made it possible to envision this educational program. The students were to receive nominal financial remuneration during their training and the School was to receive tuition fees.

This plan, which originally included the psychiatric service of the Army's Winter General Hospital, has been stabilized and improved by the conversion of Winter General into a permanent hospital of the Veterans Administration, whose chief medical officers—Major General Paul R. Hawley,

Captain Daniel Blain, Lt. Col. I. A. Marshall, Dr. Paul B. Magnuson and others—are endeavoring to carry out General Bradley's purpose of raising the veterans' hospitals to a high professional standing. Their wish to establish clinical services with a teaching program supports the purposes of the Menninger Foundation School of Psychiatry so excellently that the Director of the School has agreed to serve temporarily as Manager of the Veterans Administration Hospital in Topeka in order to facilitate the integration of these two institutions. Cooperation of the School and the Veterans Hospital enables fellows of the School to hold training positions in the Veterans Administration.

The educational program of the Menninger Foundation School is based on the conviction that graduate psychiatric training must be both extensive and intensive, that it should be systematized and standardized, and that it should include both didactic instruction and supervised clinical work. Ideas and recommendations made by various authorities and in various conferences during the past few years have been incorporated in the plan already in operation at the Menninger Clinic for fifteen years. Among these might be mentioned the Hershey Conference on Psychiatric Rehabilitation held in February, 1945, under the auspices of the National Committee for Mental Hygiene. Previous publications of the Menninger Foundation have indicated the way in which these ideas have gradually assumed practical form.

The School offers a three-year course in general psychiatry, with opportunities for further specialization in child psychiatry and psychoanalysis. The following institutions provide clinical facilities:

The Menninger Psychiatric Hospital
The Menninger Clinic—Outpatient Departments, Adult and Children's Sections
The Southard School
The Topeka Institute for Psychoanalysis
The Topeka Municipal Clinics
The Winter General Hospital, Veterans Administration

Facilities for clinical services of the Menninger Psychiatric Hospital will continue as they have been organized in the past except that a slightly enlarged bed capacity has made practicable the organization of two services under the medical director, Dr. Robert L. Worthington. In the Veterans Administration Hospital eight services are contemplated, corresponding with the standard departmentalization used in large psychiatric hospitals. In addition there will be a medical and surgical service for psychosomatic studies. A service for child psychiatry is available at the Southard School, under the direction of Dr. Mary Leitch and Dr. John B. Geisel. Outpatient services are maintained for both adults and children by the Men-

ninger Clinic and by the Topeka Municipal Clinic. An out-patient department has been organized at the Winter General Hospital.

The method of assignment and rotation to these Services will be discussed below. To be emphasized is the principle that clinical assignments will occupy one half the students' time; systematic didactic work the other half.

Faculty

Administrative

Karl Menninger, M.D., Director
Robert P. Knight, M.D., Assistant Director
Robert L. Worthington, M.D., Assistant Director
B. E. Boothe, Ph.D., Registrar and Dean of Instruction

Senior Consultants

Brig. Gen. William C. Menninger, M.C., AUS, Director Neuropsychiatry Consultants Division, Office of the Surgeon General
Lieut. Col. John H. Greist, M.C., AUS, Seventh Service Command
Leo H. Bartemeier, M.D., Detroit, Mich.
Erik H. Erikson, San Francisco, Calif.
Robert L. Worthington, M.D.
David Rapaport, Ph.D.
Robert P. Knight, M.D.
Karl Menninger, M.D.

Instructors

Myrl Anderson, O.T.R. (Occupational Therapy)
Ruth I. Barnard, Ph.D., M.D. (Neurology)
Paul Bergman, Ph.D. (Psychoanalytic Literature)
Helvi Boothe, M.S.S. (Psychiatric Social Work)
Margaret Brenman, Ph.D. (Hypnosis and Psychological Research)
Lucille Cairns, B.A. (Psychiatric Social Work)
H. Harlan Crank, M.D. (Neurology and Psychiatry)
Sibylle Escalona, M.A. (Child Psychology)
Michalina Fabian, M.D. (Psychotherapy)
John B. Geisel, Ph.D. (Educational Psychology)
Merton M. Gill, M.D. (Hypnosis)
Major Edward D. Grechwood, M.C., AUS (Special Therapies)
Edward D. Hoedemaker, M.D. (Psychiatry)
Mary Leitch, M.D. (Child Psychiatry)
Anna T. Lownie, R.N., M.A. (Psychiatric Nursing)
Lieut. Milton Lozoff, M.C., USNR (Psychiatry)
Henry H. Luster, M.D. (Electroencephalography)
William L. Pious, M.D. (Psychotherapy)
Lewis L. Robbins, M.D. (Psychiatry)
Nathan Roth, M.D. (Psychosomatic Medicine)
Robert L. Worthington, M.D. (Psychiatry)

Guest Lecturers 1945–46 (Incomplete list)

Dr. Franz Alexander, Chicago Institute for Psychoanalysis
Mr. Rowland Allen, Personnel Director, L. S. Ayres & Co., Indianapolis
Miss Julia Alsberg, Director of Vocational Counseling Service, American Red Cross, St. Louis
Maj. B. H. Balser, Chief, Section of Neuropsychiatry, AAF Regional Hospital, Lincoln, Nebraska
Dr. Leo H. Bartemeier, Professor of Psychiatry, Wayne University Medical School, Detroit
Dr. Therese Benedek, Chicago Institute for Psychoanalysis
Dr. Edmund Bergler, New York City
Capt. Daniel Blain, Director, Neuropsychiatric Services, Veterans Administration, Washington, D. C.
Dr. Hervey Cleckley, Professor of Psychiatry, University of Georgia Medical School, Augusta, Georgia
Dr. Milton Erickson, Eloise Hospital and Infirmary (Michigan)
Mr. Erik H. Erikson, San Francisco
Dr. Otto Fenichel, Los Angeles
Lieut. Col. John V. Fopeano, Base Surgeon, Topeka Army Air Field
Dr. Edwin F. Gildea, Professor of Psychiatry, Washington University School of Medicine, St. Louis
Dr. Carlyle Jacobson, Asst. Dean, Washington University School of Medicine
Dr. Leo Kanner, Assoc. Prof. of Psychiatry, Johns Hopkins Univ. Medical School, Baltimore
Dr. Ernst Kris, New York City
Dr. Rudolph Loewenstein, New York City
Dr. Robert N. McMurry, Chicago
Lieut. Col. A. M. Meerloo, Royal Netherlands Army
Capt. Aaron Stein, Chief of Neuropsychiatric Section, Topeka Army Air Field
Dr. Robert L. Sutherland, Director of Hogg Foundation, University of Texas

Prerequisites

Applicants for the course in general psychiatry should have a medical degree from a Class A medical school or the foreign equivalent, and must have completed at least one year of general internship or the equivalent.

Admission

Applicants will fill in a formal application blank, obtainable upon request, and return it to the Registrar, who will refer it to the Education Committee of the Menninger Foundation. Whenever possible the Education Committee prefers to interview applicants. It is also recommended that each applicant complete a battery of psychological tests, including the Rorschach, which is provided by the Menninger Clinic. The action of the Education Commmittee will be communicated to the applicant by the Registrar as promptly as possible.

Advanced Standing

The American Board of Psychiatry and Neurology grants one year of credit toward the three-year requirement of graduate psychiatric education for military service in neuropsychiatry. In general, the Education Committee grants second-year standing to veterans who have had a year or more of well-rounded psychiatric experience in military hospitals.

Applications for Training in Psychoanalysis

Candidates for psychoanalytic training are chosen from the fellows of the Menninger Foundation School by the Education Committee only upon thorough acquaintance and after a period of training.

Although psychoanalytic training is strongly favored, it is doubtful that additional training analyses can be scheduled until late in 1946, when the number of training analysts can be increased.

Tuition and Other Fees

An over-all tuition fee of $750 per year is charged all fellows, payable by the year or by the quarter. (Under provisions of the "G. I. Bill of Rights," this fee may be paid for veterans by the Veterans Administration.) Additional charges are made for training in psychoanalysis.

An application fee of $20 is charged, payable when the applicant visits the Menninger Clinic for preliminary interviews and psychological testing. The registration fee is $10.

Training Positions in the Veterans Administration

On the recommendation of the Education Committee, fellows of the Menninger Foundation are appointed to staff positions in Winter General Hospital for duty in the neuropsychiatric services and for psychiatric education. Staff officers in these positions receive a salary of $3640 per year. Training positions will be extended for those who make satisfactory progress in the School until the course is completed. Fellows who hold these positions are entitled to the full privileges of the curriculum, as explained below.

Fellowships

A small number of fellowships for psychiatric education are available from the Menninger Foundation.

Maintenance and Payment of Tuition under the "G. I. Bill of Rights"

The Menninger Foundation School of Psychiatry has been approved for the training of veterans under the provisions of Public Law 346 (The "G. I. Bill of Rights"). Veterans may therefore apply to the Veterans

Administration for the payment of the tuition fee and for maintenance ($65 per month for men without dependents, $90 per month for men with dependents). Doctors holding positions in the Winter General Hospital are eligible to apply for the payment of the tuition fee.

Students not Eligible for Assistance under the "G. I. Bill of Rights"

This educational program has been planned mainly to accommodate veteran medical officers and to help the Veterans Administration in the post-war emergency. Non-veterans will be admitted, however, if clinical assignments are available for them. They will be charged the same tuition fees as veterans. Non-veterans may apply for training positions in the Winter General Hospital.

Living Quarters

Since housing is very difficult to obtain in Topeka, quarters are being constructed as rapidly as possible which will be available to fellows of the School of Psychiatry, and their families. Since these are technically "temporary quarters" only, a low rental will probably be charged.

Bachelor quarters are immediately available to fellows who wish to begin work at the School before the family housing units are completed.

Schedule of Lecture Courses and Seminars

Lecture Courses and Seminars are scheduled to accommodate the enrollment of medical officers, separated or discharged, on January 2, April 1, and July 1, 1946 and on January 2, 1947.

General Plan of Instruction

A three-year program is contemplated as minimum, in accordance with the requirements of the American Board of Psychiatry and Neurology, Inc. This does not preclude certain individuals from registering for one year only and does not guarantee that a fellow who has completed one year will be permitted to remain for a longer period if his qualifications do not indicate continued residency to be desirable. In all three years the following teaching devices will be used:

One Half Time	*One Half Time*
Lectures	Supervised
Seminars and Conferences	Clinical
Reading assignments	Assignments
Research assignments	

Orientation

All beginning fellows, for a period of three to five weeks depending on the extent of their former psychiatric experience, will attend small group

seminars for the discussion of introductory psychiatric literature, for the study of history taking, the psychiatric examination, and the case abstract, and for orientation in the procedures of the Menninger Psychiatric Hospital, the Southard School or the Winter General Hospital.

Reading Assignments

A course of selected reading in the field of psychiatry and its numerous applications will be outlined for all fellows and periodic checks will be made of progress. Current literature will be reviewed at special seminars. Psychoanalytic literature will be covered in special seminars.

Lectures

Lectures are arranged in series of basic courses and advanced courses. Basic courses will be required of all fellows except those for whom the Education Committee approves specific advanced standing. The more advanced courses are to some extent elective.

The basic (First Year) courses as tentatively planned are as follows:

Neurology (1 quarter)
(Courses in Neurophysiology and Neuroanatomy will be added later.)
Psychology (4 quarters)
General Psychiatry (4 quarters)
Psychiatric Treatment (2 quarters)
Psychiatric Diagnosis (2 quarters)
Psychoanalytic Orientation (1 quarter)
Patient Management (1 quarter)
Public Speaking and Scientific Writing (1 quarter)

The advanced (Second Year) courses are planned to include the following:

Neuropathology or Advanced Neurology (1 quarter)
Child Psychiatry (1 quarter)
Hypnosis (1 quarter)
Psychosomatic Medicine (1 quarter)
Special Applications of Psychiatry: Educational, Industrial, Legal, Social, Military and others (4 quarters)
Psychotherapy (1 quarter)
Psychoanalysis (4 quarters: restricted to candidates of The Topeka Institute for Psychoanalysis)

The Third Year will be devoted to special assignments and special studies in psychoanalysis, child psychiatry, or adult psychiatry; explorations in psychosomatic medicine, criminology or educational or industrial psychiatry; and the completion of a research project.

Seminars

Seminars directed by faculty members or visiting specialists are held

daily. No fellow is expected or even permitted to attend all of these. The schedule of seminars is as follows:

Neurology and Correlation of Psychiatry with General Medicine, (Mon. Evenings)
Child Psychiatry, (Tuesday Evenings)
General Psychiatry (Wednesday Evenings) (main staff seminar)
Therapeutic Techniques, (Thursday Evenings)
Psychosomatic Medicine, (Friday Evenings)
Psychoanalysis, (Saturdays—Monthly)

Clinical Instruction

Supervised clinical assignments will occupy at least one-half of the students' working hours. These assignments will be made on the various services of the Winter General Hospital, the Menninger Psychiatric Hospital, the Menninger Clinic and the Southard School. In Winter General Hospital the responsibility of case supervision is divided between the head of the service and a consultant known as the instructor for that service. Fellows will prepare records on their assigned cases under supervision, and present case abstracts at staff conferences. Staff conferences will be held daily, at both Winter General Hospital and the Menninger Clinic. Each fellow is expected to attend at least five conferences per week; he may attend more if time permits. During the period of assignment to cases in any service or department, fellows will attend small weekly seminars held by the head of the service or the instructor for the discussion of problems in the relationship of the doctors and the patients.

Since the number of services available is large enough to permit individual programs of varied clinical assignments, our plan calls for a rotating system of assignments among the services of all the collaborating institutions. The number of available services permits some choice of assignments during the first and second years of the course, and in the third year fellows will be encouraged to choose different specialties. The Education Committee will plan with each fellow a program of clinical assignments which will insure balance of varied and intensive training and the most profitable specialization.

The clinical services of the collaborating institutions as presently planned:

Menninger Hospital, East
Menninger Hospital, West
Out-Patient Department of the Menninger Clinic, Adults
Out-Patient Department of the Menninger Clinic, Children
Southard School (residential children's cases)
Topeka Municipal Clinics
Reception, Winter General Hospital

Acutely Ill, Winter General Hospital
Neurological, Winter General Hospital
Female Psychiatric, Winter General Hospital
Psychoneurotic, Winter General Hospital
Continued Treatment, Winter General Hospital
Convalescent, Winter General Hospital

Research Assignments

It will be strongly recommended (perhaps required) that each fellow undertake a research project sometime during his training period, preferably during the third year. For assistance and direction in these projects the Research Committee of the Foundation will be available and if special funds are needed for equipment, travel or other such expenses application may be made to the Executive Committee of the Foundation.

Certificate

A certificate or diploma certifying to the work accomplished will be awarded on completion of the course.

Inter-Relationships with Other Educational Programs

The educational program outlined above applies to physicians. Arrangements are being made for the expansion of courses now being given in the Menninger Psychiatric Hospital, the Menninger Clinic and the Southard School. Courses for clinical psychologists, psychiatric nurses, psychiatric social workers, occupational therapists, recreational therapists and attendants will be described in a later announcement.

Authority

This announcement has been prepared by the Education Committee of the Menninger Foundation—Drs. Robert Knight, Robert Worthington, Karl Menninger and Bert Boothe—and approved by the senior faculty members listed on page 3. It is subject to change.

A NOTE ON THE TREATMENT OF DEPRESSIVE PSYCHOSES IN SOLDIERS

By H. M. SEROTA, Captain, M.C.*

Characteristic differences between the acute psychoses of the soldier and civilian have been remarked by some observers[1,2]. In such comparisons a superficial yet generic discreteness is evident. Both qualitatively and quantitatively these differences shed light on an aspect of superego psychology and afford the military psychiatrist an opportunity not given his civilian colleague to observe and to treat certain psychotic symptoms which are clearly the soldier's reaction to a specific, hostile, and inescapable milieu. Simmel[3,4] has recently reviewed his experience in the last war in this light.

In the following cross-sectional study of a group of 300 successive cases admitted to a special "depressed and suicidal" ward, an attempt has been made to present the most representative types of reactions and to draw therefrom certain therapeutically useful conclusions. For purposes of this discussion case examples of impulsively suicidal psychopaths who were also admitted to the same ward have been omitted.

The group of reactions herein described which differentiate the soldier's psychosis from the civilian's, appear to fall in the category of "defense" psychoses. The soldier patient, unlike the civilian patient, seems to hold intact a portion of his contact with reality, so that he preserves the attitudes and demeanor of a soldier, especially in regard to authority. This ability to make his behavior conform to the military code, in spite of a severe and disabling mental illness, deceives some observers into thinking that there is an element of simulation in the psychotic picture. An astute schizophrenic patient resentfully observed that such patients only *acted* "off."

One need only make rounds in a military hospital and ask routine questions of each patient to recognize that despite the apparent severity of his psychotic disability he automatically recognizes and conforms to the accepted officer-soldier relationship. Since a soldier on duty does not speak freely to an officer, neither does a soldier patient do so. It is an artificial and yet real situation in which the soldier's "ataxia" of emotional expression, based on the military code, is at once apparent, and colors his entire behavior. It would even seem that there is superimposition of a psychosis upon an otherwise moderately constricted personality. The reactive nature of the soldier's psychosis appears in sharp contrast to the civilian's psychosis. While the civilian displays symbolic symptoms in

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which an old conflict of infantile origin can be surmised from the exaggeration of his lifelong autistic modes of expression, the soldier presents a picture in which the psychosis is recent, and apparently strictly isolated from some parts of his personality, so that his behavior has a dual character that gives it a histrionic quality.

It is impressive to watch such patients suffer publicly and later enjoy a cigarette privately, make repetitive self-depreciatory statements to the officer and yet preserve some residua of their normal manner, physical appearance and appetite. Unlike the true involutional depressions, such depressed and agitated patients as are here described show a sleep chart of early restlessness and disturbed rest but no early morning awakening. For the doctor to imply by word or attitude that such men are "goldbricks" results only in deepening the regressive tendencies as the patient attempts to save face. To treat such patients as invalids, and thus support the desire to be "mothered," is also fraught with its dangers. The immediate problem of therapy is to protect the patient from his overbearing super-ego and its expressions in agitation, depression, and impulsive, usually unsuccessful suicide.

In response to oppressive authority, hostility and anxiety are ordinarily aroused, but the military environment does not permit appropriate expression of such emotion. Inhibition replaces the expected reactive aggression. In response to impending combat the soldier experiences anxiety, but flight is replaced by a "freeze" of self-perpetuating character which to the observer represents a retirement into illness. Amnesia while AWOL is another form of such inhibitory function. For the soldier there can be no respite, except in illness, from the demands of his environment while the civilian may quit his job or rail at his superior. The "moral code" is alone sufficiently strong to prevent such overt aggressiveness by many soldiers, and for most the Articles of War are a strong deterrent. Just how strong this sense of duty is can be seen in the verbal productions of our patients.

The sincere emotional protestations of many newly arrived patients on the closed "depressed" ward follow a common pattern. "What are the charges against me?" they cry. "Why can't I have a court-martial now instead of waiting?" or "I've messed up, I know." These self-accusations have no basis in fact; they are typical reactions to the military code of honor which the soldier has accepted. It is as if the superego were indicating that evacuation to safety must be accompanied by appropriate punishment, as must all desertion and shirking of duty in the danger zone. Because of the obvious danger of impulsive, bizarre suicide it is essential that the officer relieve the patient's guilt feelings and apprehension at once as far as possible. The closer the patient has been to actual combat operations the more severe are these reactions of guilt and self-depreciation.

The following case illustrates the severity of these guilt reactions, and shows also how totally unrealistic psychotic delusions and behavior can co-exist with correct military demeanor toward an officer.

Case Report

The patient was a 22 year old corporal who had always been a quiet, conscientious farm boy. His past history revealed that he had always been shy in the presence of girls but had some friends whose company he enjoyed. He had always helped his father on the family farm, and frequently felt called upon to improve on his father's methods. He was happy to enter the military service and with diligence and hard work was promoted to corporal in the field artillery. He shortly became depressed, felt that he was a fraud and a traitor as he had had only a seventh grade education, and would endanger his men. He slashed both wrists in a suicidal attempt, severing many tendons bilaterally. After being discovered several hours later and treated for shock and hemorrhage, he regained sufficient strength to leap out of the second floor window of the hospital. Some months later while still overseas he obtained access to a bottle of phenol while in another hospital but was fortunately under surveillance and was prevented from harming himself.

Upon admission to the closed ward he stated that he was fully prepared to stand trial, that he had deserted his outfit and, if possible, he would like to be shot. He was depressed, his voice was monotonous and low, and he showed marked psychomotor retardation. When he spoke of his supposed misdeeds there was some display of energy. As he had had actual combat experience he was encouraged to relate events exactly as they had happened in order that the ward officer might have a complete record of the supposed crime. Each day the patient would present himself at the officer's door, stand at attention and state, "Sir, I deserted my outfit." Each time this was countered with the statement that reports in Army files indicated that this was not so, and that he was merely a soldier fatigued in battle who was sent to the hospital to rest. Gradually his agitation diminished and it was possible to assure him that he could make a contribution to the war effort in civilian life as well.

At approximately this point his mother visited the hospital. She sat with him constantly, bringing fruit and candy at each visit. When he wished to talk she drew him out and constantly urged him to relate his experiences overseas. She reassured him about the future. Within a week this familiar contact resulted in such alleviation of his symptoms that on ward rounds he stated, "Sir, I didn't realize what I was like all those months."

A more common type of acute psychosis found among the patients in our group is distinguished from civilian psychoses not in kind but by the fact that it seems to be more frequently stimulated by military life than by civilian life. This is the psychotic reaction of the patient who has at the core of his personality an unsuspected nucleus of latent homosexuality. It is our impression that many patients of this type would not have been

driven into an acute panic and psychotic break if they had not been in military service where they could no longer avoid recognition of their conflict. The acuteness of the homosexual panic may abate with appropriate treatment even though the basic personality remains unaffected.

Case Report

The patient, a well developed 19 year old private, was inducted shortly after the completion of a successful high school career in which he had engaged in numerous extra-curricular activities and had made many friends of both sexes. However, his past history revealed the significant facts that he had always been concerned about a congenital hypospadias, and that his father had died when the patient was only 12 years old, leaving him in the care of a solicitous mother and older sister. He was able to make the initial adjustments to military life until assigned to a regular outfit. Soon he began to experience feelings of inadequacy when his more mature barracks partners discussed their sexual escapades. He became progressively preoccupied with his apparent deficit until he could no longer perform his duties, and then reported for sick-call because of "the jitters." He decided that his hypospadias unsuited him for a future of married life, and a well-meaning medical officer, in explaining the etiology of his condition, informed him that something must have gone mildly askew with his endocrines early in life. The patient grasped at this bit of information and arrived at a conclusion that he was a hopeless "born" homosexual. He became progressively more agitated, irritable, and hyperactive, threatening to commit suicide if any weapon were convenient, and had to be hospitalized.

Upon transfer to this hospital and admission to the "special watch" ward, he was tense, restless, agitated, and easily distracted. He misidentified people and demanded an immediate court-martial, stating that we probably would not inform him of the charges against him, anyhow. He was sure he had heard several people call him a homosexual, but did not know whether he was accused of active or passive practices. The constant reiteration by the ward officer that the patient was not a prisoner bore results after a period of a week, so that the patient could be induced to relate his history amidst his continued tearful protestations of innocence and fear of court martial.

No analysis or uncovering was attempted, but in following up the patient's freely expressed concerns over his physical deformity, he was progressively reassured that since he could have both an erection and nocturnal emission his equipment was entirely adequate. The patient continued to rub the hump on his nose as he was being addressed, whereupon it was explained that the mere physical appearance of his other appendage was entirely analogous, for he had no difficulty with his nasal function despite its shape. He smiled in response and the thesis was again emphasized with a penciled sketch. Following a repetition of the same points to which the patient listened with rapt attention he relaxed, seemed much less anxious, and soon was apparently self-confident to the point where he began to entertain other patients on the ward with his imitations

of celebrities and vocal representations of musical instruments whenever called upon to do so at talent shows. Approximately three months later he sent a letter indicating that he was again working at his old job after discharge from the service.

It would be erroneous to assume that an acute homosexual panic had been "cured" in any sense of the word, but the acuteness of the patient's fear was obviously allayed to a considerable degree. This case illustrates the image of authority which the officer-psychiatrist becomes in the mind of his soldier-patient. Similar results in civilian life have been discussed in terms of "transference cure" by Knight[5].

The foregoing case also illustrates the typical self-depreciation of the soldier patient when talking to an officer. This tendency is apparent regardless of the form his anxiety takes, the degree of his withdrawal or the depth of his delusions. If he speaks at all in the officer's presence he depreciates himself.

Since the symptoms may be aggravated by certain kinds of stimulation, it is well to study the reality soldier-officer relationship. While in the "line" the officer is commander, the symbol of the dreaded Articles of War, a demanding father, a court of public opinion and the absolute voice of parental authority to a small impotent child. He can order a march into certain death but yet is impartial and fair to all. The medical officer continues to wear this responsibility to some degree, but, in addition, offers an avenue of escape by virtue of his membership on certain medical boards.

The traditional power of the physician as a magical healer and father figure is greatly enhanced in the Army by his military officer status, but at the same time the absolute control which he seems to have of the patient's destiny may influence the patient's symptoms in the typical way indicated. The patient is induced by his fears to present himself in a light which conforms to his recent but thorough indoctrination in military code. The aggressions and unsocial behavior of the civilian psychosis are rigidly ruled out by this code. It is to be expected therefore that these aggressions will be turned in upon the self in the form of depressions. This direction of the aggressions along acceptable military lines is what is typical of the soldier psychosis and it is what gives the illness the element I have described as "histrionic." It is important to realize that such a patient is not acting worse than he feels, but that he is substituting an unnatural expression of his feelings for a natural one.

The observer may recognize several stages of change when the patient has been returned to the zone of the interior to await disposition. Initially there is usually a period of retardation, inhibition, and confusion during which the patient experiences hypnagogic hallucinations or ideas of reference and suspects that other patients and ward personnel suspect him of passive homosexuality. Occasionally the belief is concerned with active

homosexual practices; or the patient who has been shy and seclusive during the greater part of his life feels that his feelings of unworthiness are caused by his having masturbated.

Case Report

One patient who gave a history of having always been shy with girls but of having had occasional contact with prostitutes, had been a steady worker in civilian life. He had been somewhat tense all of his life. Upon entering the service at the age of 35 he made a successful adjustment, even during active combat overseas, but when his outfit was sent to the rear for a prolonged period of inactivity he developed the idea that his buddies were accusing him of homosexuality. When this became unbearable to him he shot himself through the chest with a .45 cal. pistol, narrowly missing his heart. When sufficiently recovered he was evacuated to the United States and on admission to the hospital was preoccupied, withdrawn, and terse in his remarks. He admitted strong ideas of reference regarding accusations of homosexuality and several times reported these feelings spontaneously. However, repeated assurances to the effect that no one suspected him of that at all seemed to be sufficient to assuage his tension, and within a period of four weeks he became more cheerful and helped voluntarily with ward chores. His statement showing insight was, "Those ideas I had must have been my imagination." After he was informed that he was to be discharged from the Army, he stated, "I must have been pretty nutty when I got wound up back in my outfit."

It is characteristic, in our experience, that the subsequent course of the illness is in great part dependent on the earlier structure of the patient-parent relationships and their derivatives. The more substantial this tie the more benign and hopeful is the course; the more broken and tenuous, the more malignant. And, as a valuable therapeutic corollary, the visits of relatives are to be encouraged and used with definite therapeutic intent, quite unlike the situation that obtains in civilian practice. An example of the good results of such a visit follows:

Case Report

A 21 year old private who had attempted suicide by drowning while overseas was later evacuated to the United States in a severely depressed and withdrawn state. Following the visit of his mother he became somewhat more alert and then requested to be sent to the occupational therapy department. However, he continued to berate himself and constantly voiced his feelings of inadequacy despite affidavits in the record to the contrary. Although semi-stuporous on admission, and still retarded to some degree on discharge, he wrote a long letter one month later indicating that he was gainfully employed, felt that he was helping in the war effort, and that he was again supporting his mother as he had previously done.

It is frequently possible to base a prognosis of the acute psychotic episode on this reaction to the visit of relatives, and the observer is struck by the analogy of the situation to that of a beaten and bewildered child

rescued from a totally hostile environment by its parents. Correspondingly the rôle of the medical officer becomes clear. He must appreciate that the mere presence of his insignia of rank represents not only the reality of war but also a personification of the patient's superego. Once he understands this and avoids all punitive and hostile gestures and words, it may be possible for him to penetrate the fog of withdrawal, psychomotor retardation and inhibition that envelop the anxious and frightened patient. Frequently only the pentothal or amytal interview will abolish the anxiety sufficiently so that contact may be established as Grinker[6,7] has shown.

Because of the fact that the medical officer must become a permissive and mild embodiment of self-critical tendencies, Brig. General William C. Menninger[8,9] has cautioned that the psychiatrist's own life-adjustment may be a determining factor in the future adjustment and recovery of his patient. As the burden of war is common to both, it remains for the officer to retain his emotional security and help to alleviate the superego punishment endured by the patient. This may appear trite, but it is all too easy for the therapist to voice some derivation of the theme "your buddies are still at the front" not only directly, but by timorous and insincere reassurance. In addition, the schizoid patient is quick to sense overt or even "gentlemanly" hostility and, as a result, becomes quickly withdrawn and preoccupied so that his mode of expression becomes more primitive.

It is quite possible to build up a vicious cycle of: hostility—anxiety—incoordinate blocked expression—more hostility (from harried ward attendants)—more anxiety—more blocking, etc. The cycle is amazingly like an intention tremor, and when finally the anxiety has become too great, expression ceases.

The military hospital environment itself can become an aid in therapy. If the initial symptoms are those of self-depreciation, then association with obviously disordered patients results in many cases in further feelings of self-depreciation and conformity with the demonstrated opinion of the officer responsible for the assignment. This is expressed by the formula "You must have thought I was really crazy and so you put me here." "What do I think or what have I done that was bad or that needed punishment or contempt?" The final result may then be preoccupation and agitated withdrawal. In many cases, however, where reality-testing has not broken down entirely, the disparity between how he feels and how he must look to others is recognized by the patient, and the net result may be salutary. In still others the formula may be extended to include: "You called me crazy, and that's how I'm going to act."

Interpretations made by the officer to the patient are often overvalued as are the admonitions of powerful parents to a defenseless child who in turn learns to acquiesce in order to get along. Although from the stand-

point of increasing knowledge this may be a disadvantage, this is readily compensated by the tremendous therapeutic advantage that such prestige affords. In some cases only a commisioned officer can make the statement which will assuage the guilt feelings of the self styled "deserter" who believes that he has been imprisoned on a closed ward to await court-martial. Certainly it devolves on the therapist to convey the proposition "You did your duty, but you reached your breaking point as others do when the cards are stacked against them, and a board of medical officers decided to discharge you to civilian life where you can still be of help in the war effort." A failure to achieve and convey this understanding to the patient will likely result in his continued self-torment and suicidal intent, or in a prolonged stay in a hospital at public expense.

Summary

The nature of the officer-enlisted man relationship is discussed and an attempt is made to show how that transference situation may be used to therapeutic advantage in the treatment of the acute phase of the illness. Since guilt feelings and other expressions of an over-bearing and uncompromisingly hyperactive superego may be aggravated by hostility or contempt, and result in the patient's attempting suicide or in the prolongation of his illness, the officer is cautioned about the double aspect of his rôle. Since, also, the future course of the illness depends on alleviation of the superego burden, it is emphasized that any resemblance to a punitive attitude on the part of the officer may result in a prolongation of the illness which then may be truly designated as iatrogenic disease.

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BIBLIOTHERAPY FOR NEUROPSYCHIATRIC PATIENTS*

Report of Two Cases

By JEROME M. SCHNECK, M.D.

The purpose of this report is to present clinical data on bibliotherapy in an effort to encourage further research with this form of treatment. Relatively little information on the subject is available in medical literature.

During the course of research on bibliotherapy at the Menninger Clinic a plan of study has been outlined[1], two bibliographies prepared[2, 3] and a review of the literature presented[4]. Reference to these publications will furnish the background for the development of interest in this field, demonstrating at the same time how very much remains to be accomplished.

This paper deals with two cases in which bibliotherapy has been used as an aid in treatment. In the first case it was incorporated into psychotherapeutic interviews, and in the second it was used as an adjunct to hypnotherapy. In neither instance was an attempt made to utilize bibliotherapy as the only therapeutic technique. This is hardly practicable because a separation in fact from "psychotherapy" is probably inconceivable; the first term virtually implies the second. No claim is made for the indispensability of bibliotherapy in the treatment of these patients; it has simply been a valuable aid in both cases.

The technique of bibliotherapy varies with the physician and patient. With an increase in our knowledge and experience, techniques may probably be standardized, although flexibility will undoubtedly be necessary in accordance with the requirements of the patient and the predilections of the therapist.

The various possible approaches in utilizing reading as treatment will not be discussed. Rather the methods employed with these two patients will be presented with comments or explanations as indicated.

Case Reports†

Case I: The patient, a 40 year old housewife, sought treatment for periodic depressions.

Historical Data: The family history was not remarkable. The patient was the third of six siblings, born and reared on a farm in a small midwestern community. Her social relationships in childhood and adolescence were good. She obtained a college education, paying for some of her expenses by part-time work, and then married a professional man. They

* Part of a research in bibliotherapy, The Menninger Foundation, Topeka, Kansas. For other reports, see papers listed at end of this article.

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had three children, one of whom died in early childhood. The patient taught school for several years. Her husband was friendly and sociable and both he and she were active in organizational activities.

Present Illness: Six years prior to the onset of the depression the patient had received thyroid medication for "nervousness" with questionable results. When the feeling of depression started she received estrogenic medication with no beneficial effect. Menopausal changes as indicated by oligomenorrhea began two years after the onset of the depression. The depressive episodes recurred in cycles for five years starting in the fall and ending by mid-January or February. During the last three cycles there was mild euphoria in the spring with resumption of normal behavior in the summer. When depressed the patient experienced feelings of inferiority with an inclination to limit her social contacts and loss of interest in household activities. She had feelings of unworthiness as a mother and wife and had thoughts of suicide. When mildly euphoric she was also hyperactive, reengaging enthusiastically in household and social activities. There was decreasing interest in sexual relationships in recent years.

Examinational Data: Physical and neurological examinations were essentially negative and findings on routine blood, urine and x-ray examinations were within normal limits. The BMR was minus 2.1%.

The clinical psychiatric examination revealed no perceptual defects. Recent and remote memory were good and accessibility was moderate. Historical information was furnished in organized fashion and no disharmony of affect was observed. The patient appeared mildly depressed. She had a characteristic bland facial expression which persisted unchanged throughout the period of study and treatment.

The Bellevue Scale revealed an I.Q. in the superior range. The Performance I.Q. was in the bright-normal range with the discrepancy indicating the depressive trend. There was no evidence of attention disturbance during the psychological testing procedures although some concentration disturbance was apparent. Anxieties seemed to be kept out of consciousness. Learning efficiency was excellent with everyday concept-formation superior in quality although it showed depressive narrowing. The diagnostic personality tests indicated a pre-morbid compulsive adjustment with clear-cut depressive stereotypy and meticulous thinking. There were also indications of obsessive inclinations. The Rorschach and Association Tests reflected a great tension of aggressions, and the Thematic Apperception Test revealed a sensitive woman with refined feelings and considerable versatility of associations. Despair and suicidal ideas were expressed but there was also an expression of hope for a better future.

On the basis of the history, clinical findings and psychology tests, a diagnosis of neurotic depression was made.

Treatment

The first book used in treatment was *Love Against Hate* by Karl Menninger. This was recommended when conflicts arose about mixed feelings which the patient recognized she might possibly have had toward her son during his fatal illness. This therapeutic approach was attempted because of the patient's intelligence and apparent receptiveness to psycho-

logical ideas. When this reading recommendation was made the patient was told that books were to be used in her treatment in order to enable therapeutic procedures to extend beyond the time limited to interviews.

Reading the book prompted discussion of her relative frigidity in sexual relations with her husband. This material arose in direct association with portions of the subject matter in the book. While reading *Love Against Hate* she was stimulated to consider her relationship with both her husband and her deceased son. Also while discussing the book various types of psychiatric treatment were referred to and the patient inquired about the distinguishing features between psychotherapy and psychoanalysis. Misapprehensions were clarified and the discussion as a whole served an educational function for the patient. Rapport between patient and examiner thus seemed enhanced.

Further discussion of material in *Love Against Hate* led directly to an evaluation of the patient's relationship with her parents and siblings, and her school and social activities. The patient was only moderately accessible when treatment was started and the discussion of her reading seemed definitely to increase accessibility. Through association with subject matter in this book the patient was led into a discussion of her relationships with her children, feelings of guilt involved, ideas about childhood masturbation and her own conflicts about this.

After finishing *Love Against Hate* the patient spontaneously requested further reading recommendations. In order to increase accessibility even further *The Human Mind* by the same author was recommended and conflict material likewise elicited. In addition to *The Human Mind* the patient was given the November 1944 issue of *The Bulletin of the Menninger Clinic* (Pediatrics Number). This was highly effective, functioning in the same manner as the aforementioned books. While reading *The Human Mind* the concept of resistance in treatment arose. The patient recognized both intellectually and emotionally its application to herself.

Man Against Himself by Karl Menninger was then used and the patient found the sections on suicide depressing and unenjoyable. It made her uneasy, thus confirming the impression of other workers in this field that it is inadvisable to recommend reading material dealing with suicide to depressed patients. In view of the patient's tendency to re-read various sections of books prescribed, she was advised specifically to refrain from re-reading the subject matter dealing with suicide and she readily accepted the suggestion. No difficulties were encountered.

In the same way that the concept of resistance was encountered and discussed, the concept of ambivalence was likewise evaluated in relation to the patient's family and social relationships. Additional psychiatric terms and ideas were dealt with in this way.

After reading the aforementioned psychological material the patient continued to seek additional recommendations. Her various interests were discussed and it was learned that the patient's social outlook was broad and that she was anxious to learn about people in geographical and social settings different from her own. The writings of J. P. Marquand were mentioned to her and three of his books recommended—*The Late George Apley*, *So Little Time*, and *H. M. Pulham, Esq.* The patient had improved greatly by this time and reading was prescribed as much for recreational and educational purposes now as for nuclear material for further discussion.

Further discussions of books and interests revealed a long standing desire to learn the elements of astronomy, and reading recommendations were made in accordance with this.

Shortly before treatment was terminated the patient was considering the possibility of working on a voluntary basis at an Army hospital. Among the possibilities she considered was library work, in view of her previous experience in this field while at college and her renewed interest in books. When treatment was concluded the patient requested further suggestions for reading, especially of psychological material. It was felt that this preference could be satisfied while supplying at the same time books with both recreational and educational value. The following were suggested: Gregory Zilboorg's *Mind, Medicine and Man*; Helen E. Marshall's *Dorothea Dix—The Forgotten Samaritan*; Dorothy Blitzsten's *Psychoanalysis Explained*; Clifford Beers' *The Mind that Found Itself*; and William A. White's *Autobiography of a Purpose*. A brief description of each was given and apparently the patient's wishes were satisfied.

Case II: This patient was a 50 year old married woman who sought treatment for symptoms which had been disturbing her for the preceding four months. These consisted of various somatic complaints, insomnia, irritability and a constant feeling of fatigue without the ability to relax.

Historical Data: The patient was one of six siblings, born and reared on a midwestern farm. A maternal aunt was a patient in a mental hospital but there was no history of nervous or mental disease in any other members of the family.

The patient's scholastic record through high school was good and she attended a business college following her graduation. She worked steadily as a stenographer for six years and then married a man whose occupation was that of grocery dealer but who, in more recent years, operated a small farm. For many years the patient carried the burden of business transactions in association with her husband's work and, in addition, she did part-time stenographic work. She disliked housekeeping. She was interested in women's clubs and church work, actively engaging in social activities associated with the latter. The patient had two children, one of whom was dead at birth and the other living and well at 18 years of age. She was described by her husband as being meticulously clean about her person and home.

Present Illness: Although some of the patient's difficulties started during the four or five year period prior to treatment, they had increased in intensity four to five months before she appeared at the Clinic. At that time her menstrual flow had stopped completely. She complained of "nerves", frontal headaches, generalized headaches, a sensation of fullness over the bridge of her nose, insomnia, a feeling of fatigue without the ability to relax, irritability when conversing with friends and intermittent substernal pain of ten to fifteen seconds duration with aching of her arms, precipitated by emotional disturbances but not by physical exertion.

Osteopathic treatments had been of no aid and she then received six electroshock treatments at another sanitarium, obtaining temporary relief. She then complained, however, of a peculiar, painful sensation over the areas to which the electrodes had been placed.

Examinational Data: The physical and neurological examinations were essentially negative. Blood studies and urine analysis yielded results

within normal limits. Chest and skull x-rays were negative. Four leads on an electrocardiogram revealed a sinus rhythm with normal P waves and T waves and slight slurring of QRS complexes in all leads. It was interpreted as an essentially normal EKG with the appearance of no abnormalities after exercise.

In the clinical interview situation the patient's physical appearance seemed to be somewhat younger than her stated 50 years. She seemed tense, but when it was suggested to her she leaned back in her chair and attempted to relax. There was sighing and slow shrugging of her shoulders, giving the impression of fatigue. She was only moderately accessible and quite circumstantial, avoiding conflict material when probing was attempted. Cooperativeness in other respects was good. She was alert, well oriented in all spheres, with good recent and remote memory. No perceptual defects were elicited. Thought content centered largely on her somatic complaints. Her intelligence and fund of knowledge seemed average. Judgment was slightly impaired. The patient was usually tearful and manifested moderate anxiety. No disharmony of affect was evident.

The psychological tests corroborated the clinical impression of neurasthenia. The Bellevue Scale revealed an average I.Q. with the performance level below the verbal level. The original I.Q. seemed probably to have been in the bright normal range. Learning efficiency was fair but everyday concept formation very weak. The diagnostic personality tests confirmed the given diagnosis. The association test was relatively well ordered. The Thematic Apperception Test revealed extremely weakly integrated stories with minor perceptual misrecognitions and lapses of logic. Personal relationships appeared weakly represented.

Treatment: During the first few interviews hypnotherapy was used. The production of muscular phenomena was fair. The patient was able, under hypnosis, to furnish additional details of a dream which she was unable to do in the waking state. Manifestations of post-hypnotic amnesia were poor. The patient occasionally followed a post-hypnotic suggestion. The most marked effect of hypnosis was to produce a state of relaxation which the patient could not initiate spontaneously in the waking state. The disadvantages involved were the temporary effect of benefits derived and the lack of contact with the patient during intervals between visits. Pharmacologic aids such as seconal, acetyl salicylic acid and benzedrine for the production of relaxation, control of headaches and induction of a sensation of well-being were also of temporary value, but the danger existed of producing sustained reliance on barbiturates.

When bibliotherapy was started its initial purpose was to aid in eliciting conflict material difficult to obtain even under hypnosis. The idea again was to produce material by means of associations with reading matter. The bibliotherapeutic approach could thus be incorporated into hypnotherapeutic interviews or it could be used only as an adjunct to hypnosis if this were desired.

On questioning it was learned that the patient was reading books very little but she perused newspapers and magazines. The patient was told that books were going to be used as part of her treatment and that this approach had been found to be particularly effective in illnesses such as

hers. A random choice of novel was made when Graham's *Earth and High Heaven* was prescribed. The patient was specifically directed to read at bed time starting as much as one hour before her usual hour of sleep and she was advised not to discontinue reading in the event that headaches appeared. It was suggested that no other books be read at this time although no control was attempted of newspaper and magazine reading. No time limits were set. Shortly after this novel was prescribed the patient obtained and read the book. Discussion of the story led to material dealing with the social and economic conditions in the patient's home town. This in turn led to a discussion of personalities of friends and neighbors with an evaluation of the patient's social relationships at home. The conversation turned to the patient's father about whom much conflict existed. It was interesting to conjecture about the possibility that discussion of her father was initiated through an association with a section in the story wherein attention was called to the hands of one of the characters. It had been observed during the interviews that the patient was at times somewhat preoccupied with observing her own hands and the hands of the examiner. On more than one occasion also she had remarked that her father's hands were one of the most outstanding features about him.

The patient manifested an inadequate appreciation of the feelings of one of the characters in the story toward her father. At this time she attempted to avoid a detailed examination and evaluation of her relationship with her own father.

With the avoidance of conflict material the patient expressed concurrently a sense of relaxation when reading, maintaining that her attention was diverted from her own symptoms. This feeling of relaxation persisted even after she discontinued reading.

Because of the patient's preoccupation with physical disabilities in people and the anxiety which appeared when confronted with them, Butler's *The Little Locksmith* was recommended in an effort to initiate associational material which might in turn lead to an understanding of this difficulty. The story dealing with the problem of physical disability put the patient in a "dither". She reacted to this by expressing boredom with the story and did not finish the last few pages. She rationalized her feelings by maintaining that her own educational background was limited in the field apparently of uppermost interest to the main character of the book. Following discussion of this book the patient forgot to take it with her, leaving it in the therapist's office. She expressed later a reluctance to finish it and no insistence was used.

In view of the patient's symptomatic improvement without recourse to dealing with deeper conflicts, attempts to use books for the latter purpose were discontinued. Reading was recommended for diversion, relaxation and education and the advantages of this approach were discussed with the patient whose interest had been aroused and maintained. Suggestions were made for correlating reading with her hobby of collecting antiques. The frequency of visits was decreased and during the interval periods she followed the reading recommendations. Partial symptomatic improvement continued.

On a return visit it was felt that hypnotherapy could be used again

for its immediate bolstering effect in inducing relaxation and alleviating symptoms, and it proved effective. The ability to induce relaxation by this means was invaluable but limitations existed in that contact with the patient could not, of course, be maintained in this way during interval periods. Bibliotherapy was thus an extremely valuable adjunct.

The patient began to request further reading recommendations spontaneously. She remarked of her own accord that reading had helped to induce in her a feeling of relaxation, satisfaction and comfort.

The books recommended, therefore, for an interval period were as follows: R. McKenny's *My Sister Eileen*; Dorothy Parker's *Here Lies*; Hendrick VanLoon's *Lives*; Evelyn Eaton's *Quietly My Captain Waits*; and J. P. Marquand's *So Little Time*.

The patient continued to improve symptomatically and she began to average three hours a day at reading, expressing an opinion about the soothing effect, mentioning her great interest in it and appreciating her ability to utilize spare time effectively and fruitfully in this way. She continued to seek further suggestions. Additional recommendations were Kenneth Robert's *Northwest Passage*; P. G. Wodehouse's *Code of the Woosters* and other writings by this author; J. P. Marquand's *H. M. Pulham, Esq.* and *Wickford Point*; and Bowen's *Yankee from Olympus*. These books were discussed with the patient with suggestions as to extending the range of reading of her own accord along lines of interest, concentrating on the authors preferred most.

Discussion

Bibliotherapy was definitely advantageous in treating these patients. The educational and recreational merits have been mentioned. Its aid in eliciting conflict material was important; it was felt that treatment time was abbreviated, especially with the first patient. In addition, the prescription of reading matter enabled treatment to continue during the patient's absence from the therapist, contact thus being maintained between therapist and patient. This contact may be maintained not only during interval periods in treatment but for some time after termination of psychotherapeutic interviews if it is desired to continue a therapeutic relationship with the patient after he returns home. Sudden termination of treatment is thereby avoided.

A follow-up study of these patients is not presented at this time. It is not essential for the purpose of this paper since no attempt has been made to evaluate the bibliotherapeutic technique from the viewpoint of its relationship to prognosis. The aim has been rather to elucidate the technique with case material citing merits and mentioning some shortcomings.

Care must be taken in prescribing certain types of literature. This is illustrated by the first case wherein reading material dealing with suicide disturbed the patient. In some instances the author has used books in treatment with the purpose of producing anxiety but details of various types of reading material to be used or avoided are not given here since this

paper is not intended to present an over-all picture of applied bibliotherapy. Again in the first case the patient's obsessional inclinations caused her to dwell on certain features of the psychological material. No marked difficulties were encountered but some misinterpretations had to be clarified. This need cause no concern if one is prepared for it.

To achieve the several aims of bibliotherapy many forms of literature may be used. Psychological literature is by no means necessary although it is employed often. A shift from psychological non-fiction to novels is demonstrated in one patient and avoidance of psychological material following an initial trial is described in the other. One may have a good idea about the type of reading desired in some instances, whereas in others trial and error may be unavoidable, at least until standardization in technique is effected. Regardless of standardization, however, the maintenance of some flexibility is desirable, depending upon the tastes and aptitude of the therapist.

Summary and Conclusions

Two applications of bibliotherapy have been discussed. In one case it was incorporated into psychotherapeutic interviews, and in the other it was used as an adjunct to hypnotherapy. In presenting these cases historical and examinational data have been given but the treatment described has been limited largely to bibliotherapy itself with little information about details of treatment as a whole. The progress of each patient has been indicated, however.

Further experimentation with bibliotherapy would seem to be desirable because it may possibly facilitate and perhaps hasten treatment in certain cases. Its recreational and educational merits may be valuable for some patients. Further potentialities ought to be explored and more scientific evaluations attempted. Presentation of additional case material is desirable in order to encourage further trials, substantiate findings, furnish data for broader and more complete evaluation and aid generally in the development of another therapeutic method.

OTHER PAPERS IN THIS RESEARCH

(1) Schneck, Jerome M.: Studies in Bibliotherapy in a Neuropsychiatric Hospital, *Occupational Therapy and Rehabilitation*, 23: 316–323, Dec. 1944.

(2) Schneck, Jerome M.: A Bibliography on Bibliotherapy and Libraries in Mental Hospitals, *Bulletin of the Menninger Clinic*, 9: 170–174, Sept. 1945.

(3) Schneck, Jerome M.: A Bibliography on Bibliotherapy and Hospital Library Activities, *Bulletin of the Medical Library Association*, 33: 341–356, July 1945.

(4) Schneck, Jerome M.: Bibliotherapy and Hospital Library Activities for Neuropsychiatric Patients: A Review of the Literature with Comments on Trends, *Psychiatry*, 8: 207–228, May 1945.

THE WAR REPRINT SERVICE OF THE JOSIAH MACY, JR., FOUNDATION

More than five million copies of over four hundred leading medical and scientific articles have been published by the Josiah Macy, Jr. Foundation's War Reprint Service during the last three years. These went to medical officers of the armed forces of the United States, Canada, England, New Zealand, Australia, the Union of Socialist Soviet Republics and China. This Reprint Service was discontinued January first.

The Reprint Service of the Foundation has been an effort to bring new and important developments in the science and practice of medicine to medical officers who were largely cut off from the sources of medical information during the war. In the selection of these articles the Foundation has had the active cooperation of the Committee on Pathology of the National Research Council and of the National Committee for Mental Hygiene. The articles selected for reprint and distribution were those dealing with the most recent scientific developments that had a direct bearing on medical and health problems related to military service. The distribution to the medical officers was worked out in cooperation with the Surgeons General of the Army and Navy and the Air Surgeon. Through the courtesy of the National Committee for Mental Hygiene, more than one million reprints were delivered to neuropsychiatric medical officers.

Several complete numbers of the *Bulletin of the Menninger Clinic* were selected for distribution in this reprint service, because of their application to military psychiatry.

Emotional Problems of Living. By O. Spurgeon English and Gerald H. J. Pearson. Price $5.00. Pp. 429. New York, W. W. Norton & Co., Inc. 1945.

This is an excellent book which might have been more accurately entitled "Psychological Development of the Human Being." The first twelve chapters are an explicit, detailed account of psychosexual development, sufficiently technical to be used as a textbook for psychiatrists, social workers and child psychologists, yet written so that it could be useful to intelligent laymen as well. It is one of the best accounts of the psychology of the child that is known to the reviewer, a "must" for all child psychiatrists and a "should" for all others.

The last four chapters deal with treatment in a necessarily condensed form. The object of the authors has evidently been to provide in one volume of readable length a complete guide to psychological development and to its obstacles and problems. In this endeavor they have been unusually successful. The book will also lend itself admirably to teaching purposes although one wishes that for that purpose the authors would expand the treatment section into an additional volume in order to deal with it as thoroughly as they have covered the field of normal development. (K. A. M.)

Convulsive Seizures. By Tracy Putnam. 2nd Edition. Price $2.00. Pp. 160. Philadelphia, J. B. Lippincott Co., 1945.

This is the second edition of a book which needs no introduction, its value having been well proven by the demand for it by both the lay and medical publics. In the preface the author announces material added since the first edition; this includes information brought up to date on anti-convulsant drugs, and the problems of insurance and of employment of those suffering with convulsive disorders. The chapters are briefly summarized at their beginning and a successful attempt is made to render the book readable, understandable, and uniformly encouraging. If the author leans toward optimism in his views, he has erred on the proper side. The book deserves its position among those designed for lay consumption and the additions appear to justify the printing of a second edition. (E. D. Hoedemaker)

Textbook of Neuropathology. By Arthur Weil. Second Edition. Price $5.50. Pp. 356. New York, Grune & Stratton, 1945.

This authoritative textbook of neuropathology gained a position of acceptance in its first edition; the second edition, consolidates this position. A perusal of the book convinces the reader that pathology is no longer the study of "dead" tissue; "The addition of chemical and physical data reflects the author's personal endeavor to study neuropathology not merely with the aid of the microscope but with every tool possible which modern biology puts at our disposal." The book meets the needs of both student and practitioner, and can be well recommended. (Nathan Roth)

The Person in the Body. By Leland E. Hinsie. Price $2.75. Pp. 263. New York, W. W. Norton & Co., 1945.

This book is intended as an introduction to psychosomatic medicine, and as such it deals with elementary principles. The author states that, by and large, psychosomatic medicine has to do with conversion phenomena. Certainly some will find room for difference of opinion here, although it is admittedly difficult to draw a hard and fast line between conversion and psychosomatic phenomena in general. The book deals almost exclusively with the bodily complaints of patients suffering from typical psychiatric disorders, and has little or nothing to say about the emotional factors in many of the disease processes which are usually brought first to the attention of the internist. It is easily readable and will have value to those who wish to acquaint themselves with some of the basic principles of psychosomatic medicine. (Nathan Roth)

The Principal Nervous Pathways; Neurological Charts and Schemas with Explanatory Notes. By A. T. Rasmussen. Price $3.50. Pp. 73. New York, Macmillan Company, 1945.

The third edition of this very useful book on the principal nervous pathways presents no fundamental changes in content, organization, or format as compared to the first edition. The charts and schemas illustrating the principal nervous pathways are brought up to date on the basis of recent neuroanatomic research, and the brief texts accompanying each are appropriately modified. The index is more detailed and therefore more useful.

As a supplement to a textbook of neuroanatomy and an aid to three-dimensional visualization of nervous pathways, this book is unexcelled. Unlike many compends and schematic representations, its accuracy may be relied upon. It is highly recommended for reference and as an aid in reviewing the anatomy of the nervous system. (Ruth Barnard)

Personality and Social Group Work. By Everett W. DuVall. Price $2.50. Pp. 234. New York, Association Press, 1943.

This book is particularly directed to professional and volunteer workers in what the author calls "leisure-time recreational agencies." The object of leisure-time programs is no longer simply to keep the child and the adult off the street and occupied, but is directed toward "personality growth" of the participating member. With this in mind the author goes through a painstaking process of acquainting the recreational worker with some principles involved in the study of personality.

The author's attempt to encourage groupworkers to assume a more personalized attitude toward members of their groups is timely and to the point. However, the author carries his enthusiasm too far when he later advocates the use of various psychological tests as tools in the hands of the group leaders. Recalling that he directs this book chiefly to the group-worker whose training by no means necessarily includes experience in psychological testing, this emphasis must be considered at least unwise if not altogether dangerous. (Helvi Boothe)

Developmental Psychology. By Florence L. Goodenough. Price $3.75. Pp. 702. New York, D. Appleton-Century Co., 1945.

This is an ambitious attempt to cover the entire field of developmental psychology, from prenatal development to old age, including chapters on Mental Disease, Mental Deficiency, Juvenile Delinquency and Crime as well as Mental Hygiene. The material is presented in a simple almost

conversational style designed to arouse and sustain the interest of the beginning student of psychology. Emphasis is placed upon representation of factual material and of the important schools of thought now current, and little attempt is made to integrate this material into a unified point of view. Excellent photographs, tables and figures serve to increase the interest and usefulness of the book, especially as a teaching aid for which purpose it is recommended.

The all-inclusiveness of the presentation necessarily engenders a degree of superficiality. The sections on infancy and preschool-age are especially complete and adequate, those dealing with maturity and personality deviations appear weak to this reviewer. The psychoanalytic approach is inadequately presented in a 4-page summary. (Sibylle Escalona)

The Cultural Background of Personality. By Ralph Linton. Price $1.50. Pp. 153. New York, D. Appleton-Century Co., 1945.

This little volume seems to be an attempt to blueprint the coming science of human behavior which will synthesize the findings of psychology, sociology and anthropology. Linton would add biology to this trinity but states the relationship between biological phenomenon and the other three are so poorly understood it is not yet possible to add it in a workable relationship. With little conscious recognition, the author by-passes the contributions from sociology having bearing on his stated problem, proceeds to display a very unsatisfactory knowledge of psychology, and finishes with generally sound findings of social anthropology which save the book from being totally useless. There is misuse, and contradictory use, of the terminology used in the social sciences, although it is stated that the generally accepted basic meanings have been extracted. (Richard E. Worthington)

New Directions in Psychology. By Samuel Lowy. Price $3.00. Pp. 194. New York, Emerson Books, Inc., 1945.

The author, a student of Stekel, makes an impassioned plea for social reform based upon the application of psychological knowledge. He urges that the objective of the State be to plan and foster conditions which would promote the greatest degree of mental and physical well-being for the largest number of people. The book presents a summary of psychological knowledge drawn from various sources and avowedly organized on the basis of the author's training and practice. Attempts are made to indicate applications to social and political fields. Psychological concepts, such as repression, suppression and others, are used loosely and appear to be given different meanings in various parts of the text.

Throughout the book there are many refreshing, vivid, even epigrammatic summaries and characterizations. Certain of the chapters are stimulating and thoughtful. In general, though, and unfortunately, the content is not well organized, the style is heavy and uneven and the apparent emotional fervor tends to obscure and even to disrupt continuity. (William L. Pious)

Personal Mental Hygiene. By Dom Thomas Verner Moore. Price $4.00. Pp. 331. New York, Grune & Stratton, 1944.

The author, who is professor of psychology and psychiatry in the Catholic University of America, Washington, D. C., speaks more as a priest than as a psychiatrist in this book. He argues for the inculcation of moral

standards and a religious philosophy of life as the objective of psychiatric treatment. He says, "Without ideals and with no moral and religious principles, modern psychiatry has many most unfortunate limitations," principally a lack of appreciation of the "conscience principle" which, ideally "overcomes the libido." (J. L. M.)

Psychology of Adolescence. By Luella Cole. Price $3.25. Pp. 660. New York, Farrar & Rinehart, Inc., 1942.

This book should be of interest and help to teachers for whom it was primarily written. It consists of a comprehensive discussion of the adolescent phases of physical, emotional, intellectual, social and moral growth. The author has diligently and thoroughly searched the literature for all relevant objectively proven data.

Throughout the discussion the importance of the rôle of the high school teacher in appropriately training adolescents so that they may become well adjusted, healthy adults is stressed. The book contains many case examples and much constructive criticism and advice for teachers. (Mary Leitch)

Men, Mind, and Power. By David Abrahamsen. Price $2.00. Pp. 155. New York, Columbia University Press, 1945.

In this book the author presents his views of the psychologic forces at work in Germany which led to the gigantic struggle just concluded. In the light of his criminologic and psychiatric experiences, he shows some of the unconscious, emotional attitudes which allowed the German people to accept and welcome Nazism. There are informative personality analyses of leading Nazis, Quislings and collaborationists. The book ends with suggestions for the psychiatric correction of the disordered personality structure of the German as an important step in winning the peace. (Nathan Roth)

Medicine and the War. Edited by William H. Taliaferro. Price $2.00. Pp. 193. Chicago, University of Chicago Press, 1944.

Ten subjects connected with the war and medicine are presented in lecture form by members of the Division of Biological Sciences of Chicago University. The book was compiled with the intention of presenting the layman with some of the facts, accomplishments and problems directly connected with the war and the years following it. It is interestingly written and easily read. Dr. Paul Cannon's remarks concerning the food situation in relationship to conducting a war and feeding the people afterward are sobering ones. The editor gives a good summary of the malaria situation in relation to large masses of humanity, which is followed by a discussion of the need for prophylactic epidemiological work entitled "Insects, Disease and Modern Transportation." Psychiatric problems in the services and some of the post-war problems are touched upon by Dr. David Slight. (Edward Adams)

The Eternal Ones of the Dream. By Geza Roheim. Price $4.50. Pp. 270. New York, International Universities Press, 1945.

This contribution to the psychoanalytic study of anthropological material discusses the origin and meaning of totemic mythology among the primitive Australians, and its relation to ritual as well as to the dream and the day-dream. It is a rich source book, designed apparently for technical study. (Margaret Brenman)

The Unknown Murderer. By Theodor Reik. Price $3.00. Pp. 260. New York, Prentice-Hall, Inc., 1945.

The title of the book is misleading in that it bears only an indirect relationship to the content. The author states that the law court is not the right place for psychoanalysis, which can best serve criminology by research investigation into some of the problems involved in criminal justice. He leaves no doubt in the reader's mind that the greatest problem is the psychological naivete of judges which has led to terrible miscarriages of justice. He displays a lesser zeal in investigating the psychological meaning of the interest of everyone in finding the perpetrator of an unsolved crime, despite an introductory statement to the effect that this is his primary purpose in writing the book.

The method of approach to the investigation is a genetic one. It leads to a discussion of many interesting facts and speculations about the habits and superstitions of primitive and extant savage tribes, a few speculations about the psychology of the murderer and suspect, and also to the conclusion that despite years of social and cultural alterations we have not been entirely successful in overcoming the animistic thinking of our ancestors. (Mary Leitch)

Psychology of Sex Relations. By Theodor Reik. Price $3.00. Pp. 243. New York, Farrar & Rinehart, Inc., 1945.

In a vague way only, the title of this book is related to its contents, which consists in a rather disconnected series of chapters which contain occasional flashes of brilliant intuition but which are, for the most part, devoted to repetitious refutation of the identity of love and the sexual impulse. It is especially astonishing that an old student of Freud should have succumbed so completely to what Dr. Ernst Lewy has called "the return of the repression," and so completely missed or forgotten Freud's own definition of his use of the word sexual and Freud's revision of the old libido theory. (K. A. M.)

The Therapy of the Neuroses and Psychoses. Second edition. By Samuel H. Kraines. Price $5.50. Pp. 567. Philadelphia, Lea & Febiger, 1943.

In the preface to this second edition, the author announces the inclusion of new material concerning Schizophrenia and new chapters on the *Shock Therapies*, the *Organic Psychoses*, and the *Neuropsychiatric States Induced by the War*. To "provide space for the new material" he has "deleted the chapter on Psychoanalysis and Related Schools."

The first five chapters are devoted to classifications and descriptive material, the fifth chapter having to do with sex drives. The remaining 15 chapters are complete expositions of the author's view of psychotherapy and reveal his psychobiologic orientation. Much good case material is presented to illustrate therapeutic procedures. The long recognized rôle of direct discussion of etiologic factors of which the patient feels he is aware is carefully detailed. The chapter on the states induced by war deserves praise for its comprehensiveness and practical suggestions.

The book should be of value to general practitioners especially and to those psychiatrists whose interests lie in the direction of physiologic and environmental etiologic agents as the objects of their therapeutic efforts. (E. D. Hoedemaker)

Personality Factors in Counseling. By Charles A. Curran. Price $4.00. Pp. 287. New York, Grune & Stratton, 1945.

The writer of this book on non-directive counseling is a Catholic clergyman with psychological training. Michael Ready, Bishop of Columbus, has contributed the preface and Carl R. Rogers, Professor of Psychology, University of Chicago, has written the introduction. The author's aim is to gain further understanding of the processes which take place in counseling interviews and which lead to changes in the patient's personality.

The book is intended for the use of "all those whose work brings them in contact with personal problems—educators, doctors, nurses, social workers, priests, and religious people generally, to mention only a few." It contains case studies with reproductions of phonographically recorded interviews, analysis of the interviews and the author's conclusions.

While the book is elementary to therapists trained in the dynamic school of psychiatry, it contains much valuable material for the group for whom it is primarily intended. (Helvi Boothe)

Active Psychotherapy. By Alexander Herzberg. Price $3.50. Pp. 152. New York, Grune & Stratton, 1945.

This small book by a German refugee psychiatrist practising in England, describes psychotherapy based on four measures: "psychoanalysis, persuasion, exertion of direct influence on the patient's environment, and tasks given to the patient." The author states in a preface that he differs from the orthodox psychoanalytic theory in "finding the distinguishing characteristic of neurosis and perversion not in experiences, but in a set of mostly inborn character dispositions of a non-sexual nature." This, he states, leads not to therapeutic nihilism, but to his active attitude.

The author's "psychoanalysis" is a form of expressive psychotherapy utilizing some dynamic insights. His "persuasion" and "environmental manipulation" represent no departure from the usual manner of using such techniques. His chief emphasis is on assigning tasks to the patient. This technique of task setting apparently results in dividing patients into two groups: those whose positive transference and ego strength makes them capable of responding rather quickly, and those who "cannot be cured at all because their dislike of tackling their life problems is much greater than the unpleasantness of their illness." It is difficult to understand why the author fails to apply his understanding of transference to an evaluation of the "task therapy." (Merton M. Gill)

Women and Men. By Amram Scheinfeld. Price $3.50. Pp. 453. New York, Harcourt, Brace & Co., 1944.

This rather wordy book is an encyclopedia of information pertaining to all the differences of males and females in all phases of growth and development, from conception to death, and in all spheres of behavior and accomplishment. Wherever differences exist, Mr. Scheinfeld focuses his statistical attention, be it a difference in height, shape of head, strength or stamina, mortality or morbidity, pulse rate, reproductive function, genius, criminality, and so on *ad infinitum*. He draws on anthropology, sociology, eugenics, embryology, physiology, biochemistry, and the behavioral sciences of psychology and criminology, to tell his readers not that men differ from women, but how they differ and to what degree. Being an informal, enlightened, but quite unsophisticated book, the reader drifts from *tete a tete* conversations to inspiring statistics, to humorous illustrations, to over-simplified pictorialgrams, and back to chatty small talk about what significance may be attached to the difference discussed. (Henry Luster)

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PROGRAM OF THE VETERANS ADMINISTRATION FOR THE PHYSICAL AND MENTAL HEALTH OF VETERANS*

By CAPT. DANIEL BLAIN, M.D. (USPHS)†

I bring you the greeting of General Omar N. Bradley, Administrator of Veterans Adminstration, who is well known to all, and of Major General Paul R. Hawley of the Army Medical Corps, Acting Surgeon General of Veterans Administration, and their thanks for this opportunity to let you know what we are thinking about in the Washington Headquarters of VA. General Hawley particularly regrets his inability to accept your invitation in person. I have the privilege of representing him because the paramount interest of this group is in the realm of emotional ills, mental disease, and especially in the far wider field of personal relationships. The department of Neuropsychiatric Services is interested in each of these phases also. We too feel that the emphasis over a long period should and must inevitably shift to the realm of personal adjustment and maladjustment, as the front line of attack on human ills in the emotional field.

To orient ourselves, I would like to suggest a point of view about veterans. We can speak of veterans for we in the positions of administrative responsibility are all veterans ourselves, or will be when we get out of uniform.

More important than medical problems is recognition of this fact. Our veterans are men and women who have added to their assets of three or four years ago a wealth of experience. They have traveled and seen the whole United States and the world. They have faced hardship at the front, on the supply line and in tiresome tasks in the planning areas at home. They have had the supreme privilege of offering their all for the sake of life, liberty and the pursuit of happiness for themselves and their families and their countrymen. We would like to hope for the whole world. They are therefore men and women of broader vision, more maturity, and wiser experience than they were when they left home. That is what we must always keep in mind. Veterans are our greatest national asset—the most

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important element in every city and community. Every village, town and city, county and state, needs what these veterans have to offer. And our future will in large part be measured by the part we let them play in community efforts.

The Community's Responsibility

Each World War graduate needs to make use of his increased assets, his added skills, his broad horizon, his wealth of experience. If he finds no opportunity to use them, they will wither and die. Used muscles grow larger and stronger. Unused muscles atrophy and the nerve pathways die. Unsatisfied urges toward usefulness not only die but, worse than that, retire to hidden depths of the soul where they build up hostile aggression, which escapes in anti-social necessities, which poison both the owner of the urges and those with whom he comes in contact. The veteran needs the community and the community needs the veteran. The responsibility of using the veteran in every constructive effort and encouraging the further growth of his capabilities by putting them to use—this responsibility and opportunity lies in his local environment, among his friends and neighbors, in his village or town or city or county.

Success or failure, however, affects an ever widening circle. These ripples that emanate from each generating unit, each veteran, must not be vicious, antisocial, discouraging, hostilely aggressive. They must be kindly, warm, invigorating ripples that unite all of us in really constructive effort and that increase understanding, sympathy and unity in ever-increasing circles, and that join with other such beneficent influences to make the whole nation united, strong and friendly.

In this picture of the veteran and his future, medicine plays only a supporting rôle. The healthy man wants no contact with doctor or hospital. And the vast majority of our men and women are healthy in every way. We would not have loud-mouthed sad-toned jeremiads pouring from every microphone and printed sheet on the great numbers of physical and mental disabilities of our veterans. Let the world be acquainted with the vast majority of our men and women and what they have to offer. We would not have you feel that those who are sick are unimportant. The total number of participants in the war is so huge that a relatively small percentage needing medical care constitutes a large and important problem. Human nature is the same in the nation as in the family. One crippled child will draw a great part of the affection and care of an entire family. And our sick veterans need have no fear that they will ever be relegated to an unimportant part of the nation's interest. But, in directing our efforts to medical care let us not forget to nurture the great asset of the healthy man, so that he may not become part of the sick group.

The medical department is empowered by the people through their Congress to furnish a strong supporting framework in the realm of health, to the other benefits the nation has provided for its war graduates. (Parenthetically, War Graduate might also be a fitting term for veteran—the word "veteran" has the connotation of age and many of our men are not old, but they are all graduates of the war college of the university of life).

Men must be healthy to make use of their opportunities and to fight against obstacles. We therefore must stand ready to aid in a return to robust health when the occasion arises. And we must be acutely aware that prevention is better than cure and we must forestall the need for medical care in every way possible. The finest medical care is expensive in terms of time lost, energies wasted, families disturbed, and anxieties aroused. Our public health experts in state and county, and in the medical schools, and especially in the United States Public Health Service, are our close partners in this aspect of our responsibility.

Standard of Medical Care

Generally speaking, you should know that the medical department of VA recognizes that a very large responsibility is already at their doorstep in the men now ill who have already been released. And you should know that we are sure of sound and complete and most generous backing from the people through Congress of every proposal that can be shown to lie in the path of constructive, sound medical policy. And we are sure that that backing will continue as long as good medicine is practiced, both in accomplishments and planning. We therefore state that the standard of medical care which will be available should be the best that modern medicine can devise, and that we will work toward that end and nothing lower.

It will take longer to achieve that goal in some localities than in others. In some places there may be little at present with which to start. A very minimum would be the best that any citizen in any community can now get. But there are conditions in some localities that are indefensible and the VA will move as fast as humanly possible to raise the local standard, at least for its own veterans. This will necessarily raise the standard for the entire community. An example of what is meant is the practice still found of lodging psychotics in local jails in lieu of a hospital. This type of antediluvian, pre-civil-war, neglectful and ignorant care for mental patients must be changed immediately, as far as veterans are concerned.

So much for physical structures. Standards of medical practice, with relation to certain specialties cannot be changed overnight. The backbone of medical practice in the United States is the general practitioner. My hat is off to him. As a specialist myself I took with reverent awe to the man who can and does do so many kinds of things, who turns down nothing.

The progress of medical science has gone so far that no man can be a specialist in everything. In a sparsely settled county, therefore, a half-dozen isolated doctors may not have among them a specialist in cardiac diseases of children, or a brain surgeon, or a qualified psychiatrist competent to treat the milder neuroses. That we must accept. But we would plan so that in five or ten years every area would have a specialist in the major fields and our people would not be satisfied if this were not so. And we expect to give opportunities to all practitioners to get short training courses in various specialties, and we can, for the veteran, create a public demand that no doctor remain static in the face of medical advance. We are not satisfied with second-rate skills, and we will work toward the best that can be achieved.

In the meantime, we are thankful that most general practitioners, though lacking in some of the fine specializations which are so earnestly desired, yet possess one ingredient which makes up in part a lack of technical skill. I refer to the inherent qualities of the family doctor, his total interest in his patient, and all that he does, an appreciation of one's place in the family group, of all factors which affect him in addition to the special pathology. These men love people, and go to superhuman efforts to do something for their patients. This often is of more value than technical skill. It is necessary that as we help create specialists we see that they do not lose the personal touch. The achieving of high standards in medical care must always include the human element.

Coöperative Care

Secondly, the total number of veterans is a large slice of the total adult population. It would be impossible to give segregated care to all. It would also be unwise, for men do not thrive in isolated conditions. They are happier if their wives and children, parents and friends are treated as they are. Medical facilities are hardly enough to go around. They have to stretch in every direction. From the standpoint of good medical treatment (the proper use of available medical personnel and physical buildings and equipment) of both the veteran and the public, it is our policy to merge with available medical installations, hospitals, clinics, and use available medical and auxiliary personnel on a share-and-share-alike basis where it can be done. We have now 97 hospitals and relatively few out-patient clinics operating independently. We are building more hospitals in the next two years and setting up a number of special clinics for veterans. There is likely to be a greater spread of out-patient facilities in proportion to hospitals and it is in them that cooperative ventures are more likely to develop.

It is worth considering that sharing of veterans hospitals with other groups, when proper reimbursement of the Federal government can be achieved, may result in far better medical care of veterans than the isolated plan. Just now we operate under legal statutes which do not permit a change in policy. I am personally interested in studying the possibility of a change in this cooperative direction. Of course, there must always be some for veterans alone, for the general contentment of patients is such an important ingredient of therapy. The necessity to remain a part of a total community group, and to fight the paralytic palsy of withdrawal from the world, points strongly toward participation with other groups even in the area of sharing an illness.

Out-patient clinics will exist in some places for veterans only, but the great majority of out-patient care will be cooperative ventures.

The sharing of doctors is another must in the cooperative field. We cannot get enough full-time doctors to take care of veterans. This does not disturb us, however, for doctors need variation in their experience. They will do better if they divide their time. Some need part-time private practice to augment an income. Others are already committed to other institutions and are not available on a full-time basis, but they may be induced to share their time. Private practitioners, both in city and county areas, will see many veterans. Certainly they will not treat veterans alone, for others in the community need care also. It, therefore, is our policy, made necessary by the situation that exists, and in line with the best theory of medical practice, to reach out and secure part of the time of practically every member of the medical profession. Suitable financial recompense will be arranged. Personal satisfaction in playing a part in the care of our veterans and in participating in a program dedicated to progress and the highest quality of medical care are other inducements. I can assure you that membership in the team of Bradley and Hawley, fighters for everything that is good for veterans and the public, will yield ever-recurring sources of satisfaction.

Another general principle which guides VA medical practice is the use of ancillary medical skills. In modern medicine no doctor works alone, without failing to realize much of his effectiveness. The fields of nursing, medical and psychiatric social work, clinical psychology, occupational therapy and physiotherapy are well known and need no comment except to affirm our need and utter helplessness in the medical care of veterans if such aids were denied. Efforts in these directions have already met with some success. Pay schedules for nurses, social workers and clinical psychologists have been approved which in some respects are higher than the prevailing rates in agencies throughout the country. Attendants, particularly in mental hospitals, are the fingers of the doctor—the contact points with

the patient the greater part of the time. The importance of their service is recognized and steps are being taken to secure the best.

Special Services

We are happy to announce a new department—that of Special Services, patterned after that of the Army. This department will provide other aids to therapy, such as libraries, gymnasium activity, recreation in all forms, and other services to patients.

A source of vast potentiality that has been brought forward by the war, though it is as old as human nature, is Volunteers. No more valuable aid to therapy exists than those who come because they want to and are not paid, who bring in the breath of the outside world and keep a hospitalized patient from losing his contact. There comes with such people the visible evidence of the love and affection of America for its heroes—patients see from day to day not only doctors, nurses, orderlies, technicians, professionals in the fields allied to medicine mentioned above, who must perforce under the best of circumstances remind a man that he is ill, but the butcher, the baker, the candlestick maker, lawyer, merchant, chief—the champion boxer, local athlete, world-known artists—prominent people, pretty girls—stars of the amusement world. Some volunteers will be members of organized groups—such as Red Cross, D.A.R., A.W.V.S. I have been much impressed by local groups under the leadership of capable men and women who have selected good citizens, old and young, to visit and work with a certain hospital or convalescent home. Volunteers from the local community by and large are of more value than casual visitors, for they come often enough to get acquainted and form a lasting influence. Both are valuable. This is old stuff to you, but it is not old in Government hospitals.

Another asset which we would like to develop is the wholehearted support and intelligent interest of the maintenance staff of hospitals and clinics. Our patients see the outdoor groundsmen, cooks, waitresses, cleaners, elevator operators, doormen. It is important that they feel they are a part of the therapeutic team, as indeed they are. And that by word and deed they will encourage the patient to get the best out of hospital care. The morale and small labor turnover in places where all employees are brought into group meetings have amazed those familiar with personnel difficulties.

All welfare organizations and veterans organizations, as well as personnel groups inside and outside of the Veterans Administration, need to be brought into a working relationship with the hospital unit.

The last group, and perhaps the most important, not usually employed directly, are the clergy. The history of the war is full of instances where courageous members of their group have provided the saving factor in the morale of a company, or have helped a G.I. to get through his ordeal.

Counselling in the spiritual realm must be always included in the services available to every man.

Neuropsychiatric Units

We have now 97 hospitals of which 14 are for tuberculosis, 51 are general surgical and medical and 32 for neuropsychiatric cases; but the neuropsychiatric cases comprise sixty-one per cent of the entire medical load. The anticipated increase in neuropsychiatric hospital beds will be met by 9000 beds in the next two years and by another 9000 in the two years following.

You will be glad to know that all general and tuberculosis hospitals will have neuropsychiatric units providing care for acute cases and usually providing for treatment for at least a brief period of time. All neuropsychiatric hospitals will have a certain number of general medical and surgical beds. In this way two important needs are met. All types of patients will be served in all units and neuropsychiatry will be kept safely where it belongs—inside the world of general medicine. No psychiatrist will be allowed to forget that he is first of all a doctor and secondly a specialist in psychiatry. This should follow for all those who are in fields related to psychiatry. All psychiatrists first get a thorough grounding in general medicine and surgery, then they go into psychiatry. Psychiatrists, social workers and clinical psychologists and those who do counselling in all fields of human adjustment should get some general medicine first.

Outpatient Clinics

A large part of treatment for veterans should be in out-patient clinics. This is an important step in prevention. Early treatment is the best preventive of a more serious illness with long hospitalization.

We are now planning a series of branch clinics in thirteen major centers. These will be all-purpose clinics with departments for all needs. The setup of the Neuropsychiatric Section will illustrate the plan. After an initial screening on admission, a patient is sent to either a diagnostic service or direct to a specialist. The Neuropsychiatric Service will consist of a Chief Psychiatrist and a number of part- and full-time psychiatrists, a case worker, supervising social worker, with a number of psychiatric social workers, and a chief clinical psychologist with several lower grades under him. These clinics will be large affairs. The one in New York is four large floors. Adjudication of percentage of disability will be done by a separate corps of doctors. Paper work will be reduced to a minimum, freeing the doctors for straight medical effort. These clinics will be located in the largest cities.

The most widespread plan which follows the course of using existing organizations is achieved by contract with local clinics. Veterans with service-connected disabilities will be referred by a regional office and treated by the clinic for a fixed fee which will include usually whatever auxiliary aids are required. Five such contracts are now operating and arrangements for further contracts are in process of completion. We are greatly in need, in the Neuropsychiatric Division, of information in all states as to the availability of clinics ready to provide services. In New York the State Charities Aid Association is making a survey for us outside the metropolitan area. In these clinics, also, arrangement for examination for adjudication of disability and insurance will be made separate from therapeutic efforts.

For private practitioners who are seeing veterans, arrangements are being made for referral. Here the matter of responsibility is somewhat different. Some plan for qualification of doctors will be worked out. Some plans for referral and payment are now in existence and will be studied to see if they are satisfactory. There are certain practical difficulties which must be overcome in connection with clinics and private practitioners. The matter of subpena of records, the rendering of abstracts, clerical aid, are involved. Every effort is being made to get these details ironed out and get on with the matter of taking care of the veteran when he needs it, and not some time later.

Special Projects

You will be interested in certain special projects in the sphere of hospitals and allied institutions.

There will be 275,000 women veterans. We expect to have sections or wards for women in strategic places throughout the country. There will be no hospital for women only. It is better for the women, better for the men and better for the doctor that when women are admitted they shall go to hospitals where men are also present. We are sure that, since some of our women have to be sick, we can count on a happy influence on men patients when they are around. As they get better, association in recreation, exercise and occupational therapy will have a good effect on all.

We are much interested in our older patients. You may know that the life expectancy of the nation is increasing so that there may be more of the old age class as time goes on. Social security plans cease at 65 and many who should be busy will have to combat idleness as well. We are therefore thinking seriously of establishing a mental hospital to which will go some of our mental patients over 60 or 65 years of age, and no younger. The science of geriatrics, i.e. the treatment of old age condi-

tions, is coming increasingly to the forefront and we would like to see that our older men get the advantage of highly specialized care.

There is a borderline between hospital and outside world which some patients need to inhabit at times. Patients who are getting over a psychosis but are not ready yet for home. Patients beginning to get sick who may be saved from more serious illness. Patients suffering from relatively mild anxiety states who must not be hospitalized, yet who don't do well in the city clinic. Men or women who came back in good shape from the war, though very tired and tense, who met hard luck or a run-around and are beginning to go sour—who may break and allow a residual battle neurosis to be reactivated. These men need a place away from home, in the country, where the environment is moderately controlled, where there are people who take an interest, volunteers around to talk to, freedom not possible in a hospital, and a few well trained people to direct their care. Such would be, first, a psychiatrist interested in this type of problem, with nurses and social workers taking care of major medical needs.

Such places can be opened quickly, are less expensive than hospitals, allow more outside therapeutic aids to reach the patient. They have been tried in several instances with recognized success. The rehabilitation centers of the Army Air Forces, the center for Royal Naval ratings under Com. Scott-Forbes at Cholmondeley Castle in England and the rest centers for merchant seamen in the United States are examples of such a plan. One of these informal residential psychotherapeutic convalescence and treatment centers could be opened easily near any town or city. The country convalescent home can grow like mushrooms out of the ground whenever the idea may take hold. There are great potentialities here for cooperation between state, county or city organizations with the VA. It is our hope to try this plan as a pilot scheme to study its possibilities for care of veterans.

Readjustment Centers

Along the same line and possessing some advantages not present in the country scheme is the Readjustment Center actually to be incorporated in many general and mental hospitals. This unit is for milder and convalescent cases mentioned previously but will be in a part of the hospital building or in a separate building on the same grounds. While not having the free country and village atmosphere and being close to major illness, it has the distinct advantage of being included in the same administrative setup of the hospital, and it has already been approved and will be an actuality before long. This provision for the care of the in-between stages

of illness we regard as one of the great advances in the care of the sick which the VA is ready to announce. These, of course, are only associated with hospitals and hence will not occur in any great number.

Colonel Esmond Ray Long, who is Chief Consultant on Tuberculosis for the Office of the Surgeon General of the Army, is now organizing superior standards of care for the 6,900 tubercular patients in our Veterans Administration Hospitals. Five new hospitals for tubercular patients have been authorized which will furnish 2,550 more beds. Also, 1,598 beds will be added to hospitals now in existence. Colonel Long is on loan from the Army.

There are needed some aids to the care of patients in mental hospitals which come in the area of legal medicine. Patients who should not be allowed to go out on their own responsibility and who may be suicidal or homicidal should be subject to some kind of legal restraint, with the consent of the family, which will apply to all states, and not vary with each state line. Matters of guardianship and permission to use certain well recognized and thoroughly reliable tools in diagnosis and therapy should also be studied for inclusion in such general permissions and restrictions for all veterans hospitals.

Veterans Administration Homes

Besides hospitals and clinics, one of the great services afforded to veterans is in the National Home Service, now called Veterans Administration Homes. Here in 12 homes, caring for 10,000 men altogether, live our veterans who need a home, rather than the care given in hospitals. Veterans Administration Homes have a new director. He is V. B. Kincaid, who has been with the Veterans Administration for the past 26 years.

We have in mind an extension of the broad concepts of physical medicine in many of our hospitals. There are some which are remote from the main centers of population but which possess the advantages of plenty of space, farms, orchards, and special projects of a semi-industrial nature. Much needs to be learned about improving the lot of semi-permanent injuries, of those afflicted by diseases which have reached a more or less static condition. Plans are yet in an embryonic stage but more will be announced before long. The orientation of our convalescent care will be in the direction of work. Patients will not be permitted to lie in bed and look at the ceiling. Whenever possible, the permanent semi-invalid will be taught a trade whereby he can earn money even though hospitalized.

Neurological patients will often bridge the gap between straight organic lesions of brain, cord or periphery, and the more functional types where organic conditions are ill-defined. There are the group of peripheral nerve injuries, the group of head injuries which may develop various

cortical or basal syndromes, the paraplegias, and the cord injuries. These will need much physiotherapy, occasional surgery, almost always some psychotherapy. It seems best to care for these men in general medical and surgical hospitals as part of the neuropsychiatric service, but generally in separate wards from the psychiatric patients, close to medicine, surgery and especially available to Occupational Therapy and Physiotherapy. Here again we feel much can be learned to augment present knowledge in caring for the latter stages of such conditions.

We have given you a picture of the general plan of treatment and some of our ideas and aspirations. Not all have been approved but we hope some day to show concrete examples of what we are now dreaming.

Training of Personnel

There remains to tell you of our greatest problem—personnel and the training of more personnel. It is common knowledge that our hospitals have been overcrowded and understaffed. And because of these difficulties, training of physicians in our hospitals has notably been absent. Recognition of our hospitals for residencies and internships leading to the Specialty Board qualifications in any field has been withheld and rightly so. It has also been difficult to explain to the public why training, in our hospitals, of the doctors working there was necessary for better care of the patient, and that it was the patients who were suffering in the long run. It has been long known that the best medical care in the United States was obtainable at no cost by the indigent who was eligible for the teaching wards of our medical schools. Here were available whole teams of therapists, working together with the patients, and the patients were the recipients of the finest, most advanced medicine. Our veterans will never be experimented on, but they should have the advantage of the care of young, alert minds always moving in the direction of bettering existing procedures and of older men who are stimulated by young, curious fellows who serve to keep the older men on their jobs. No dry rot is possible here and no cerebral arteriosclerosis can exist in a doctor for years without being discovered. So we are going to provide opportunities for training in every hospital in which it can be arranged. And most new hospitals will be built near teaching centers.

A pilot experiment is now starting in the Hines General Medical and Surgical Hospital in Chicago. Forty-eight residencies have been created and are being filled. Added medical supervision and treatment is obtained by getting several hours a day of the time of the leading surgeons, internists, specialists in heart, kidney, orthopedics, psychiatry, all fields being represented. It will be only a short time before this hospital, because of its treatment standards, its well trained personnel and its training oppor-

tunities for residents, will be accepted by all the Specialty Boards, guaranteeing to its patients, all veterans of the world wars, the finest treatment anywhere in the United States. A similar plan will open in Minneapolis in a short time.

A parallel pilot scheme has started in Winter General Hospital in Topeka, Kansas. In it we will have neuropsychiatric patients chiefly, along with general medical and surgical, some acute and some of longer duration, including some of the men who just need a home. We will send there a number of young men coming out of the Army who want to extend their experience in neuropsychiatry and eventually obtain rating by the American Board of Psychiatry and Neurology as qualified specialists. Teaching and treatment will be in the hands of the large and well qualified staff of the Menninger Foundation for psychiatry, aided by specialists from nearby cities.

We will have good oportunities for training men in neuropsychiatry in small numbers at nearly all teaching centers in the country. The plan is worked out and announcements will be sent to all interested, especially those in medical centers who are receiving inquiries.

A trial institute for giving aid to general practitioners in a two weeks' course is being set up in the State of Minnesota under the auspices of Dr. Thos. A. C. Rennie, Asst. Professor of Psychiatry at Cornell Medical School, and the National Society of Mental Hygiene.

Social Work

A noteworthy training program is planned by Miss Irene Grant, head medical and psychiatric social worker of the Veterans Administration. While not yet approved in every detail, the plan is to secure jobs for 80 students of social work who have qualified under Civil Service at Grade P&S 2 but who by the new standards are now short of this grade, to spend a year at a Grade #1 position, under a highly qualified case work supervisor in a hospital or clinic, three days of each week being devoted to on-the-job training and three days for classwork. Money is also available for special courses when individuals wish to enroll. When this program is on its way, we will have an upgrading system in the Veterans Administration to be proud of; all the while, remember, giving better and better care to our veterans.

In the meantime, the good work going on in social work supervision in some of our hospitals is recognized by six of the top-flight social work schools in the country who are sending some of their students for part of their training. We hope all the best schools will be sending students before long.

One of the most exciting training programs going on has been quietly proceeding since last April. The Medical Services and Vocational Services of 25 VA hospitals have sent teams for training to the Institute for the Crippled and Disabled in New York. These teams consist of the chief of physical medicine, one of the psychiatrists, a social worker, occupational therapist, a physiotherapist, sometimes a physical director, a representative from Vocational Advising Service and Vocational Training Service. This is teamwork in the real sense, all learning together. It is found to result in better teamwork in the care of patients. Again our veterans will receive better care.

In listening to this rather long and detailed, but I feel surely necessary, elaboration of our program and services, I hope you have received one strong impression. That is, that the Medical Department of VA, and, speaking for myself, the Neuropsychiatric Services, are approaching the problems involved in adequate care for veterans with only one guiding principle—that whatever can be done, can only be done by a successful integration of all medical forces in the country, flanked on all sides by the ancillary disciplines closely allied to best medical practice. And that these professional skills need a solid background of community support both for the healthy as well as the sick veteran. We are humble about what can be done in Washington, and the use of branch offices in 13 areas is but the first step in a decentralization policy which must go down to the roots of our social structure, to each individual citizen. With the backing of the best minds in every art and skill and technique we may send out guiding policies that are wholly good, but we in Washington cannot do the job because we do not actually touch the veteran. The real application of whatever good policy may be created, or the use of whatever fine piece of equipment the Federal Government may have purchased, the application of real knowledge and skill, is in the final analysis in the hands of you people who live with the veterans or who work with them.

I like to go back to the human body for an analogy which I believe is apropos of the point. Let us consider the vascular system. The heart pumps the blood, but if the strong rhythmic impulses originating from the left ventricle are not aided by a real elasticity and tonus in the arteries, and arterioles, the force is soon dissipated and only a higher blood pressure will get the blood around. And if the veins have lost their tonus, and the valves their elasticity, blood will not return from the dependent parts and stagnation results, with edema, varicosities, local ulcers. The life stream is choked. And it is not the heart which actually touches the tissues but the blood, and, only in the smallest units, the tiny terminal capillaries. It is here that nourishment finally goes out and enters the tissues. The

power of the heart pump is of no practical value until, with the local aid of each tube through which it goes, it pushes the life blood all the way to the final step. So you, the individuals, the essential unit of society, are the only means whereby anything good that comes from the pumping station in Washington or any place down the line can reach its ultimate goal—contact in and with a veteran.

The heart can be stopped by a single accident or worn out by slow attrition. But there are more arteries and veins and arterioles and venules and billions of capillaries. Therein lies strength. For things can go wrong here and there, and a few capillaries may be knocked out, but other channels form, and circulation is restored.

It is important to remember that the heart can only pump out what it receives from the whole body. People in Washington cannot work without the raw materials of ideas, and money, coming from the people of every part of the country. The blood is thin or enriched as it receives into its stream on its way to the heart, nourishing items of calories, minerals and vitamins which come chiefly from food taken into its digestive system. The ideas and skills which each of you can contribute to the common good and send into the stream on its way to the central pump will only be of value if you are absorbing from your daily experiences things worthwhile, synthesizing them in the gray matter of serious thought and sending them on their way to be used for the common good. The VA would like to function as the full representative of the people—using what you give us—coordinating the material, perhaps furnishing opportunities for more and better cooperation. Let none of us ever forget that we owe any power or strength we may have to the nourishment you send us. With all of us doing our part, perhaps we can achieve the highest pinnacle—the operation of a small part of the central government which is truly of the people, by the people, for the people.

THE FREEING OF INTELLIGENCE*

By GARDNER MURPHY, Ph.D.

I

To those who earnestly believe that psychology may serve this generation in its struggle for democracy and world order, no task would appear more important than the wise integration of pure and applied psychology. That, then, will be my theme. I shall try to approach the problem with that immediacy and concreteness which the shortness of time requires, by choosing one specific example of what a unified pure and applied psychology might achieve.

The problem to which I invite you to think with me is the maximum utilization by *homo sapiens* of those amazing cerebral hemispheres of his. He has wit enough to make for himself a happy sojourn on this planet and the gradual realization of more and more of his creative powers. He has wit enough to study, to understand and to control the predatory impulses of his kind, and to enrich and magnify the impulse to tenderness and good will. Yet he foams and frets, exhorts and moralizes. A visitor observing the Roman Empire, then joining the *Little Prince* among the minor planets, and returning in 1944, might note that intelligence, as the capacity to adapt the environment to one's needs, has been only very ambiguously advanced. He would wonder why man puts only half his mind into the discovery of the solutions he needs for his problem of community living, giving many of the critical decisions to the direction of blood rather than brains. Perhaps, he would conclude, brains are not *free* to act in accordance with their potential. Intelligence is fettered by manacles whose design has been imperfectly studied.

Scientific thought, as a full-fledged device for the analysis of nature, has been with us but three centuries. If the Lord asked some modern Job, "Canst thou bind the sweet influences of the Pleiades, or loose the bands of Orion?", he might well and modestly reply, "Not yet, but I have measured the distance and the magnitude of the Great Nebula in Andromeda and have weighed the invisible companion of Sirius." Indeed, wherever the task is objective and his intelligence free, he has remade the order of the world. Yet on points concerning his own nature, where his impulses have beclouded the process of his thinking, he still relies upon exhorting, moralizing and argument. He has not, in fact, studied with any great persever-

* A condensed version of a longer paper of the same title, delivered as the Presidential Address at the 52nd Annual Meeting of the American Psychological Association in Cleveland, Ohio, September 11, 1944; and first published in the *Psychological Bulletin*, (42: 1–19, January 1945) by whose permission it is reprinted.

ance the very process of thought itself, and is only dimly aware that the discrepancy between the achievement of science and the achievement of everyday thinking is due to failure to make clear the fetters which bind the thought processes. He has hardly heard Spinoza's precept: "be not angry, and complain not, but use reason." For how, otherwise, could a species producing the achievements of a Newton, a Darwin, or a Pasteur, prove incapable of ordering the relations of men in community, in nation, or in the world pattern of civilization? The towering genius of the great scientist often lapses into childish babblings as he turns to problems in which his personal desires give structure to his thought. When the will to believe, or the will to disbelieve, rather than to observe objectively and read the scroll of nature, is the guide, the sharpest tool of thought becomes suddenly dull, the greatest of creative impulses falls into the reiteration of petty prejudice.

I would fully concede that simple economic fears, fears of the powers that be, can muddy the thinking of all men, including those classed as scientists; but I would urge a much more systematic and deep-probing study of the less obvious constraints which we unwittingly impose upon the freedom of our thought. Thought, we say, is loaded by individual personality trends, or we speak of austistic thinking. We know that the ordered process of thought exhibited in the textbooks differs substantially from the thinking which we ordinarily encounter; but as to the specific dynamics responsible for the difference, and about the manner of freeing ourselves from these impediments we know little. For though the faculty psychology can be honorably buried, the realm of intelligence still remains separated from the realm of impulse, feeling and motivation, not only in the pages of our textbooks but in most of our experimental studies.

We may trace for a moment the different paths which pure and applied psychology have followed in their study of the human capacity to think. Psychology discovered during the seventeenth and eighteenth centuries that the process of thought could be rather effectively reduced to associative laws wedded to an elementary mechanics of brain processes. The tradition of David Hartley and the tradition of René Descartes were finally fused in a nineteenth-century associationism based upon sensory and motor elements arranged serially or in patterns. The problem of active or creative thought was solved by giving some elements in the associative stream a more central role than that assigned to others. The impulsive or emotional factors guiding thought were treated as secondary classes of elements arranged like the pieces of a mosaic pattern. Thought was basically an ordering of experiential items; and if at times the deeper dynamics of living appeared to confuse or distort the thought process, the distorting factors were made a subsidiary class of elements to be dealt with as a subordinate

problem, in accordance with associative laws. The solution was, then, solidly intellectualistic.

Early in the present century, Gestalt psychology challenged the assumptions of associationism, turning to an emphasis upon the mind's structural properties. Intelligence was given a position of high importance, creative thought assigned a central role, because the mind was deemed capable of grasping with a single stroke the inherent order and beauty of natural objects in a natural order. But the Gestalt psychology was still concerned, as association psychology had been, with the truth-seeking and truth-realizing aspects of such intellectual conquests. There was scant recognition that the mind is an evolutionary product in which the impulsive life gives quality and direction to the cognitive effort. Though many brilliant studies have been devoted by Gestalt psychologists to the nature of thought, such dynamic systems are conceived to arise directly from the structural properties of the external situation. While psychiatry on the one hand, anthropology on the other, have constantly stressed the bondage of thought to obscure, or even unconscious, directing tendencies, the implications for the experimental psychology of thinking appear still to be very incompletely realized.

Applied psychology has, on the other hand, been confronted throughout its existence with just those forms of thinking in business and industry, in clinic and in court, in school and in public opinion, which arise from a matrix of needs, and consequently provide major clues to the affective organization of the thought processes. Clinical psychology is intimately concerned with the distortion of the patient's world-view by affective factors in open or covert conflict with one another; while in the evaluation of the patient's intellectual resources the clinician observes the limits imposed upon the patient's intelligence by his need to see, to learn and to think in accordance with his drives, exhibiting a functional level of intelligence far removed from the measured capacity revealed by any test.

Here, then, as I shall try to show, is a supreme opportunity for an integrated psychology, dealing with the whole human being, to develop in a direction permitting the thought patterns of mankind in their natural setting to contribute to the understanding of the dynamics of thinking, while the psychologist of the laboratory, reaching to meet him, strives to integrate such findings within a single systematic effort.

II. Autism

Let us attempt a more systematic statement of what we know today regarding the relation of our needs to our processes of thought, and of the directions in which research may prove fruitful, if intelligence is to be free to do its task.

If we set out to order what we know about the specific relations of cognition to the life of impulse, we might schematize the steps as follows:

First, at a sheer descriptive level, perception, recall, and thought tend to take a direction such as to bring to the individual a cognitive situation satisfying to his needs.

Second, this movement of cognitive processes in the direction of need-satisfaction is often unconsciously directed, the individual achieving a wish-fulfilling end by steps which do not betray to him the origin of the impulse which he follows. This appears to be simply because one of the needs is to keep himself happy regarding his own motivation. In the cases reported by psychoanalysis, the individual reaches his goal, remaining unaware that the pseudo-logical steps taken serve an unconscious need.

Third, this tendency of cognitive processes to move in the direction of need-satisfaction appears to be a special case of the law that *behavior in general* moves in the direction of need satisfaction. I refer here to the whole mass of data on the psychology of learning which, however phrased, define the customary elimination of the frustrating aspects and the fixation of the satisfying aspects of behavior processes.

Fourth, as to perceptual dynamics, it would appear that relatively unstructured perceptual situations are given structure in terms of *figure and ground*, by virtue of the fact that those elements stand out as figure which have previously been present as aspects of satisfying situations. The series of experiments from the Harvard Psychological Clinic* are, I think, convincing here. Thus personal needs serve to throw some elements of a visual or auditory pattern into the role of figure so that one sees or hears what one needs to see or hear. A little later I shall try to show how large a part is played in thought by those needs to which we usually refer under the term "curiosity" or the "exploratory drive". As a general principle it appears enough to say that thought, like perception, is bi-polar, the dynamics of figure and ground deriving jointly from the structural properties of the stimulus situation and from the need-patterns of the individual.

In view of this preliminary analysis, it should be clear that not only the wish but the fear may be father to the thought. In many learning situations, autism derived from fear may be repeated and fixated. The impulse to perceive the nature of the threat is activated by the need to escape; this appears to be a way of coping with threats developed through earlier experience with such threatening situations. In anxiety one may repeatedly recall that which has brought on the greatest distress.

We have emphasized that autistic responses are learned responses. Since these steps in perceptual development are like the steps in motor learning,

* Cf. Murray, H. A. *Explorations in Personality; a clinical and experimental study of fifty men of college age.* New York: Oxford University Press, 1938.

we shall perhaps ultimately find that the dynamics of autistic perception are the same as the dynamics of the motor learning processes, that the perceptual world is conditioned and molded as is the behavior world. If research reaches such a point, it would make applicable to the psychology of thought everything we know about the psychology of learning.

It may be objected that laboratory studies have to do with thought encumbered by complications, that despite such complications, the bare, primordial form of intellect remains as a matrix or substrate. There is conceived to lie, beyond all these deviations, pure intellect *qua* intellect. Now indeed if pure intellect is to be found, we should go to the ends of the earth to find it. Pure intellect free of all personal autistic deviations would indeed be the pearl of great price, the discovery of which would constitute a master stroke not only for psychology but for civilization. Where, then, is this pure intellect, this Faustian homunculus, this little gem of rationality to which we strive to gain access in our experiments in the psychology of thought and in our metrical analysis of intellectual functions? Possible approaches to its discovery might appear to lie in rigidly controlled laboratory research; but here we have found that cultural and personal variables have consistently affected not only the amount but the very structure of the process of thinking. Or we might seek it in early childhood; but here thought occurs as an aspect of a type of global effortful contact with the world in which the non-rational and the egocentric mark the process and the product. Or we might seek it in the works of pure genius; but here the biographer and the historian have consistently pointed to the impress of personality upon even the most logical ordering of scientific relationships. There is, we sadly conclude, no such pearl of great price, no intellect which stands apart from the concrete personal, drive-directed efforts at contact with reality. There is no "pure" intelligence at all.

When one looks at the process of thinking in this way, seeing the impress of personal tensions and the resulting personal ways of thinking at every phase in the development of the mind, many of the formal problems relating to intellect take on a very different appearance. An example is provided by our bitter struggle over the nature-nurture question as it relates to intelligence quotients. Intellect has been conceived on the one hand to lie dormant as a potential within the germ cell, waiting only to be nursed into expression. It has, on the other hand, been conceived to be the impress of a system of social arrangements mediated to the growing individual. Studies undertaking to evaluate the relative contributions of variance in nature and nurture have yielded the ambiguous results likely to characterize statistical treatments when theory proceeds in confusion or from contrasting frames of reference. Some clarification has come from the many hints that the influence of superior environment may lie partly in the qualitative and quan-

titative transformation of abilities as a result of the arousal of the child's interests, the development of tastes, and the specific forms taken by the "will to learn;" the drive structure of the child gives direction and expression to his measurable intellectual powers. In the light of such observations it appears likely that in relation to intellectual tasks there are two levels at which personality variables may operate: 1. they may give structure to that which reaches consciousness; 2. they may, through fear, completely prevent the mind from making contact with certain specific stimulus materials. Inhibition or blockage may appear when there is a profound emotional incapacity to give the mind to the material at all. Conversely, we should expect that a positive love of certain stimulus materials would give a better-than-average opportunity for close attention to it, with a likelihood of achieving greater "resolving power" in relation to it. Autism, the movement of cognitive processes in the direction of need-satisfaction, involves, then, both the figure-ground patterning of given situations and also the crippling or the enhancement of mental functions in accordance with conscious or unconscious drive-patterns.

The comment has cautiously come that perhaps the influence of motivation in directing the processes of thought may play a part in the differential rates of growth among the different *kinds* of intellectual capacities, the mind being progressively sensitized to specific aspects of the environment which take on meaning for the individual. Perhaps when the data permit us to understand the qualitative changes wrought in intellectual functions by various kinds of influences, and to measure their amounts, we might go on to ask about their gross aggregate in the form of intelligence quotients. We can hardly expect to understand mentality as a whole until its specific expressions have been accurately observed and measured in the growing individual.

Curiosity

If one accepts the broad conception that thought, like everything else in life, reflects the dynamics of motivation, there is likely to arise a word of despair, concluding that if this be so, there is no truth, there is no science, there is only the realization of satisfactions. Yet this, I think, is a naive conception of human nature and indeed of animal nature generally. For it is because thought makes contact with reality that it has appeared in the course of evolution. Sense organs may not mediate the *ultimate* reality, whatever that may be, but they do mediate the first reality with which adjustment is made. Paraphrasing what Marx said to the idealists, "We do not know what reality is, but we can adapt it to our needs." There is truth, and there is science, as exemplified by physics and by medicine, which are not only immediately useful but which surely suggest that we are

more in touch with reality than we were three centuries ago. For the sense organs and the brain are developed as a reality-mediating system of tools; and the bi-polar organization of perception is always anchored partly upon the structure of an external world with which we must deal.

But there is an additional factor guaranteeing the integrity of the scientific enterprise. There is not only a good system of receptors; there is also a powerful positive motivation to make contact with reality; this motivation is frequently more powerful than any personal drive which might lead to escape from such adaptation. For creatures like ourselves it is necessary to keep sense organs and brain in contact with the world, constantly varying the perceptual pattern just as we constantly vary the motor adjustments, making sure of the utmost use of the tools of observation by which each pattern is constantly checked against other information. This is a way of saying that the curiosity impulse is one of the most powerful, one of the most difficult to assuage, that man possesses. It is characteristic of primates to explore about rather than to stop to digest the convenient banana; and it is characteristic of boy and girl to pry into matters to see what makes them tick.

As Wertheimer so earnestly insisted, it is the nature of man to lean hard upon the external structure-giving aspects of reality. He *needs* contact with reality even more than he needs escape from it. He can develop such a craving for contact with reality as will sweep away petty personal autisms and the smug sense of cultural rightness. If this analysis be sound, the curiosity motive would apparently serve, as other drives do, to determine the figure-ground relationships of perceptual patterns. Curiosity would throw some aspects of the stimulus into relief. The curious mind constantly sees new figure-ground possibilities, and this is why. as a probe of reality, it far surpasses the petty limitations of ordinary autism.

Immediately we ask: what aspects of a pattern yield the true figure? May not the same pattern of phenomena lend itself to different types of structuring? Yes; a composite phenomenon presented to people with varying types of curiosity will lead them in varying directions. Different cultures, and different individuals, dealing with the same perennial phenomena, have made sense of them in different ways. The cooperative venture of science serves in some measure to integrate the individual curiosities of individual scientists.

Relaxation

Thus far, I have praised the active life of curiosity, and have not hesitated to speak of the *struggle* for contact with reality. But there is another approach. We of the West are prone to forget that water quietly freezing can burst a granite that no sledge hammer can crack. There are latent

creative powers which wait to move forward to their work when freed from the restless downward pressures of the alert mind, creative powers which spring into being when once the narrow, nervous, preoccupied world of waking activity steps aside in favor of a quiet integration of all that one has experienced; when one is willing to let the mind leave harbor and travel fearlessly over an ocean of new experience. Under profound relaxation there are some impulsions which wield a benevolent despotism over thought which the whip of concentrated attention cannot control; thinking is still motivated, but motivated with less immediacy in relation to the tasks of the surrounding world. The historical record of creative thought and the laboratory report of its appearance today are equally clear that creative intelligence can spring from the mind which is not strained to its highest pitch, but is utterly at ease.

We have begun to realize that it is characteristic of fantasy to be more *creative* than is logical thought, in the sense that more cues are woven into the composite texture determined by many needs; in the same way the dreams of the night, starting from a complexity of individual determinants, achieve not simply a bizarre but in many respects a highly creative end-result. There is a tendency to overlook the real implications of the psychology of the dream, particularly if one is concerned solely with the therapeutic problem of the unconscious wishes portrayed in the individual case. More important for psychology as a science is the creative character of the dream itself, realizing, as in Coleridge's Kubla Khan, a power and an intensity to which waking fantasy is usually alien. This is not because the dream revealed fewer of Coleridge's interests or needs; rather, because more of them were free to pool their energies, to integrate their contributions. The dream gives us, as in a natural laboratory, a device for introducing more personal variables and consequently a richer permutation of end results. It would follow that a more systematic experimental study of the dream might give us a wider view of its creative potentialities, oriented to more aspects of reality than waking life can afford to recognize.

One aspect of our practical Americanism, our surviving frontiersmen's psychology, with its emphasis on wide-awake alertness and with a touch of Calvinistic devotion to immediate duty, is a suspicion of all these mental states which seem, according to the standard, not to "get us anywhere;" a general disvaluation of the relaxed, the casual, and the exploratory. The dreamer awakes from an extraordinary vivid, realistic, intriguing dream, an experience which, if encountered in a novel or a play, he would cherish as a new avenue to the meaning of life. "A funny dream," he yawns, and by the time he has his nose in the morning newspaper he has forgotten it. To disvalue the dream is to prove oneself a sensible man.

One state is perhaps still more important, because it can be better controlled, namely the hypnotic state, in which there has recently been a marked increase in interest. The great utility of hypnosis lies, I believe, in discovering that imaginative richness, that creative power, that capacity to knock down and reassemble the ingredients of life which constitutes independent, unconventional, non-routinized, original thought. The hypnotic thought may indeed be trivial if the individual experimenter so expects. But because we live under a profound cultural disvaluation of all mental states but that of rapt alertness, the fact that we have here a markedly less constrained and more creative type of intellect has infrequently attracted our attention. Perhaps the experimental use of hypnosis may lay bare the impediments, the blind spots, the personal autisms which encumber the intellectual powers of the subject, may lead to a more focussed integration of the associative resources which lie in the background of his mind.

I believe, then, that there is evidence that functional intelligence can be enormously enhanced, first by the systematic study and removal of individually and socially shared autisms; second, by the cultivation of curiosity; and third, by the art of withdrawal from the pressures of immediate external tasks, to let the mind work at its own pace and in its own congenial way.

There are probably other important principles which I have overlooked. But the time is favorable for a thorough study, by every means and through every approach, of the processes by which intelligence works, to the end that its potential be no longer stifled and frustrated, but utterly liberated. Perhaps the major contribution which psychology can make to this generation is to show how intelligence may be freed of the incubus which sits upon its chest, and to enable a free intellect to cut through the hideous confusion of today.

LOOKING BACK OVER THE YEAR AT THE SOUTHARD SCHOOL*

By JOHN B. GEISEL, PH.D.†

Sometimes it is said that a glance in retrospect at certain intervals is beneficial in evaluating experience for its bearing upon present work for future plans. Fortunately, experience is cumulative; and what may appear as an important conclusion today has been preceded by months or years of experience. The same factor would undoubtedly apply to the findings that we might list now in answering the question, "What have we learned at Southard School during the past twelve months?" Recognizing this qualification, let us consider a few major findings that seem to have emerged during the past year.

Operating in Balance. First, we may probably say that we have found it possible to operate Southard School in balance, with a minimum average enrollment of twenty-two children. Closely related, is the emerging conclusion that a larger enrollment of, say, thirty children instead of twenty-two, would be helpful in several ways: (a) helpful in increased service to society, (b) helpful economically through increased income without increased administrative staff and overhead, (c) helpful in providing much better opportunity for wise grouping in education and recreation therapy.

Additional dormitory space has been provided in one of our two large residences: in all, there are fourteen large bedrooms. At the present time only one of these rooms is occupied by two children, but there are at least seven other very large bedrooms which could adequately accomodate two children apiece. Nevertheless, we have been reluctant to pair off children in the same room, except when such arrangement would actually operate to the advantage of both children. Assuming, however, that favorable combinations of children could be made for the extra large bedrooms, a total of twenty-two children could be housed in the two large residences. Children living in boarding homes would, of course, raise the total number of children enrolled to thirty or thirty-five.

Six of our children are at present living in boarding homes. The number of children in boarding homes, however, is a fluctuating number, for the boarding home period is usually transitional for the child, between residence in Southard School and return to the home situation. During the past year, thirteen boarding homes were used and fifteen children in all were treated in these homes. It would be possible to have twelve or fifteen children in boarding homes, so far as boarding home facilities and super-

* Presented at the Annual Meeting of the Trustees of The Menninger Foundation in Topeka, December 4, 1945.

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visory services are concerned. The ratio of children in boarding homes to children in residence at Southard School has usually held at around one to two, or in other words, one-third of the total enrollment of Southard School children are usually in residence in boarding homes while two-thirds of them are in residence in Southard School dormitories.

In three instances it was possible to make arrangements for parents to take up residence in Topeka for a short time in order that the initial period of the child's return to his family might be supervised.

Need for a Children's Sanitarium. In the second place, we have learned that the Southard School, with its open buildings and lack of a closed ward or isolation room, cannot successfully treat children who are continually destructive and/or at least occasionally dangerous toward other children. Experience has shown that the behavior of this type of child is disturbing to the other children and interferes with our treatment program for them. At the same time, our lack of facilities in handling the excessively disturbed child precludes rendering the right kind of service to him. It has been necessary in several instances this year to discharge a child because his behavior was destructive or dangerous to other children—a child who, nevertheless, seemed to us to have a good prognosis, provided the right kind of control could be part of the treatment.

Our thoughts have run with ever more conviction to the idea advanced by former directors of Southard School, namely, that we should have a children's sanitarium. Such a building should always be available for the placement, temporarily or on a more permanent basis, of disturbed children. During the past twelve months, eighteen children who might have been accepted for a children's sanitarium have been rejected after Out-Patient examinations; and thirteen who have applied for admission to the Southard School have been refused even before examinations were made because their histories and descriptions indicated behavior beyond our control—behavior presenting managerial problems not feasibly met without the facilities of a children's sanitarium.

Grouping. A third finding of the year is the conclusion that small groups of, say, two, three, four, or five children and one adult, may be used as therapeutic devices both in the recreation and education program. Although grouping requires careful selection of children for the group and careful selection of teachers and recreation therapists, experience has taught us that there are a number of gains made by the child from group life that are not available for him in a totally individual program. Among these might be mentioned (a) meeting the disciplines inherent in group living, (b) sharing in work and play, and (c) gaining security from personal investment in the same room (as in school) or in the same places and activities (as in recreation). Furthermore, the child's experiences in the group, written up daily

as they are for the use of the therapy, provide significant material to the psychotherapist in his work with the individual child.

With the recent addition of a highly trained director of recreation therapy we anticipate further exploitation of group work in the recreation program. The director, who has had a wide experience in group work and in teaching, will also contribute materially to the In-service Training Program for recreation therapists.

Adolescents. We have become increasingly reluctant to take adolescents over fifteen years of age because of their need for wide community social activities. It is difficult, if not impossible, to provide adequate and at the same time acceptable supervision in such instances. For the adolescent himself it is disconcerting to have friends in a junior or senior high school group learn, sooner or later, that he resides at a school for maladjusted children. We have learned that foster home placement should be made soon after an adolescent is admitted; or, if this step cannot be recommended as an immediate one, it is better not to take the child. If the School's enrollment were larger, it might be possible to set up a program of social activities for adolescents independent of the community. Even so, this could be only a transitional arrangement, for, as soon as the child acquires friends in public schools, he should be placed in a foster home where he can return social courtesies without embarrassment.

Staff. A fifth, and in a way the most interesting finding (not new to the present year) is the great devotion that a staff member gives to his work with disturbed children. Time after time a new staff member changes in attitude from matter-of-factness to one of pervading devotion. It may be that this change of attitude on the part of the staff member is a concomitant of the nature of the work with disturbed children. Although it has been possible to revise salaries slightly, the income of housemothers, teachers, recreation therapists, and companions is still so small as would seem to work against the unselfish devotion that characterizes their service. In any case, experience shows that the devotion of staff members goes far beyond ordinary expectations and materially enhances the School's effectiveness while also holding turnover of personnel to a minimum.

The average number of children under treatment at Southard School during the past year was twenty-two. The program of treatment required the full-time services of thirty-one and one-half people of various skills and assignments as shown in Table 1. It is interesting to note that there are three categories, namely, teachers, recreation therapists, maids and cooks, that have a noticeably larger number of persons than the other categories. These three categories account for just about two-thirds of the entire staff, 20.3 in all.

TABLE 1

Number of full-time employees September 1, 1944, to June 1, 1945

Teachers	9.7
Recreation Therapists	5.6
Maids, cooks	5.0
Housemothers, night nurses	3.2
Secretaries, stenographers	2.4
Therapists, psychiatrists	2.0
Social Workers	1.5
Administrators	1.5
Maintenance men	0.6
Total	31.5

Consultant in Child Analysis. We have arranged for a consultation relationship with Erik Homburger Erikson, who since his first stay of one week in October has come for a week of consultation every seventh week. Dr. Erikson's time is devoted to consulting with the entire Southard School staff and especially with the psychiatric social workers, psychotherapists, and psychiatrists.

Need for Funds. The past year has also clarified our need for funds, foremost of which is a fund for children whose parents cannot afford to pay the cost of treatment here, of necessity expensive because it is so intensive. Not a week goes by but that two or more likely applicants are discouraged from taking further steps because the financial position behind the children is insufficient. Just as I write, two such applications have been placed before me.

We have also learned that people are interested in donating funds to the Southard School. Some $7,000 have been accepted for various purposes in the past year. One parent who purchased a home in Topeka in order that she might have psychiatric help during the first few months of her daughter's return home from Southard School, donated the property to the school when she returned to her permanent residence in the East. This home is now reserved for similar uses in the future.

Just recently a section of the very spacious veranda of one of the residences has been remodeled into a children's library. At the investment of some money and a great deal of time, this children's library has been outfitted to be one of the most attractive spots in the school. New books, for which $500 has been set aside for the present year, are carefully selected for recreation, education and bibliotherapy. This children's library is already providing excellent experiences for the children.

One remodeling project now under contemplation will provide, in a very adequate building, a series of offices for therapists in order that all psycho-

therapy may be provided on the same grounds. Office facilities, waiting room, and stenographic help will be available for this special part of Southard School treatment.

The year has been fruitful. In the opinion of the school psychiatrist and the director, twenty-six of the thirty-two children treated have definitely improved. This despite the fact that we have continued our work under a number of handicaps. It is not always necessary to have an ideal situation in order to render service. On the other hand, insofar as the service of the School is handicapped by lack of funds, facilities, or methods, we inevitably head toward securing the funds, providing the facilities, and improving the methods.

BOOK NOTICES

A Psychiatric Primer for the Veteran's Family and Friends. By Alexander G. Dumas and Grace Keen. Price $2.00. Pp. 214. Minneapolis, Lund Press, Inc., 1945.

The title describes this book exactly. It was written in collaboration by a psychiatrist, who has had long experience with veterans, and a skilful popular writer. The content is sound and substantial. It is centered about the problems of the uninjured veteran, the physically injured who requires more treatment, the physically injured man who requires only job rehabilitation, and the mentally wounded. Many short case illustrations are used which are sensibly condensed, and make their points well. It is a book which relatives of patients in veterans' hospitals and veterans undergoing treatment by physicians under the new Veterans Administration plan will find exceedingly useful. (K. A. M.)

Principles of Dynamic Psychiatry; Including an Integrative Approach to Abnormal and Clinical Psychology. By Jules H. Masserman. Price $4.00. Pp. 322. Philadelphia, W. B. Saunders Co., 1946.

In the preface to this book the statement is made, "During many years of lectures . . . the author has sought for books which, breaking with tradition, would present the fundamentals of dynamic psychology and clinical psychiatry briefly, clearly and systematically."

Certainly, in the presentation of this volume, the author has broken with tradition in no uncertain manner. After outlining the shortcomings in the behavioristic, psychoanalytic and psychobiologic schools of thought, he proceeds to build up a "general biodynamic theory of behavior," based largely on animal experimentation, and apparently oriented toward bringing biologic and psychologic phenomena into closer relationship. Such a presentation, in all likelihold, will appeal to medical students, in view of the nature of the remainder of the curriculum. (Nathan Roth)

The Psychology of Women: A Psychoanalytic Interpretation. Vol. 1, Girlhood. By Helene Deutsch. Price $4.50. Pp. 399. New York, Grune & Stratton, 1944.

The Psychology of Women: A Psychoanalytic Interpretation. Vol. 2, Motherhood. By Helene Deutsch. Price $5.00. Pp. 506. New York, Grune & Stratton, 1945.

This is a woman's psychology of women. It is intuitive, warm, emotional, somewhat unsystematic, wordy, zestful, and eminently graceful, particularly where it engages in open or latent polemics. It is not objectively scientific in the sense of being free of evaluations. On the contrary, it propounds a definite philosophy in which specific feminine qualities are not only believed to exist but are frankly extolled because they alone, in the author's opinion, allow women a life of satisfaction. We may regard such a philosophy as symptomatic for the cultural trend of our time and Deutsch's book will greatly reinforce this trend.

Some of the concepts of *The Psychology of Women*, particularly those of "feminine masochism," "feminine narcissism" and "motherliness" seem destined to remain basic for our understanding of women. Many persons

will undoubtedly disagree with some details, but this work must be regarded as the first report on psychological territory which up till now has never been mapped. (Paul Bergman)

What's the Score in a Case Like Mine? War Department Pamphlet 21–35. Price 5¢. U. S. Government Printing Office.

There is a valuable message in this little pamphlet for every veteran who has been discharged from military service because of a psychiatric disorder. It contains much information given in a straight-forward and simple manner. There are specific instructions to the veteran as to what steps he ought to take to overcome his difficulty. Above all, it is truthfully encouraging. All those who are concerned with the rehabilitation of veterans should have a liberal supply of these pamphlets for distribution to psychiatric dischargees. (Nathan Roth)

Our Inner Conflicts. By Karen Horney. Price $3.00. Pp. 243. New York, W. W. Norton & Co., Inc., 1945.

The first part of this book, it seems to the reviewer, is superficial and of little practical value; the latter part, particularly the chapters on Externalization, Sadistic Trends, and Resolution of Neurotic Conflicts contains much excellent material. The author's style is distinctly different from that of her previous books; if somewhat duller, it is definitely more gracious. The reviewer does not agree with many of the assumptions but the book is written in a dignified style and in a fair spirit. (K. A. M.)

Essentials of Neuro-Psychiatry; a Textbook of Nervous and Mental Disorders. By David M. Olkon. Price $4.50. Pp. 310. Philadelphia, Lea & Febiger, 1945.

The author of this book approaches the study of mental disease largely from the standpoint of genetic defect and physiologic dysfunction. Nowhere in the book is adequate emphasis placed on the rôle of dynamic psychologic forces in the etiology of emotional disorders, and, in general, the psychologic problems of mental disease are grossly neglected. The descriptions of ordinary psychiatric syndromes are given in obscure and inaccurate fashion, and no student could gain from this exposition a clear understanding of such syndromes. In general, the book cannot be recommended for student or practitioner. (Nathan Roth)

Stone Walls and Men, a Modern Criminology. By Robert M. Lindner. Price $4.00. Pp. 487. New York, Odyssey Press, 1946.

The author undertakes the ambitious task in this book of an analysis of crime which includes the correlation of psychoanalytic, cultural, economic and political forces. He defines crime in terms of the relationship of the criminal act to the personality of the offender and maintains that only when the criminal act represents a specific acting out of a repressed conflict, is it a crime. He refers to other situations as law breaking which may result from accident, ignorance, illness, or a sincere devotion to principles which conflict with the prevailing ideology. He feels that there is a continuum in criminal acts; at one end of the line is simple law breaking, progressing as the personal needs become more and more involved, toward

real criminal acts and ending in psychotic behavior. He conceives of the criminal act as a situation in which the ego compromises with unconscious forces and that the act itself serves to relieve tension and thus maintains the integration of the individual.

In the course of the book, the author reviews such subjects as libido development, fixation, regression and other mechanisms lying behind neurotic conflict, cultural, economic and other social forces which serve to precipitate criminal behavior in a person so pre-disposed. He calls attention to the difficulties and errors in the various studies which have been made of crime, and is very critical of the present system of imprisonment and punishment. He makes a striking suggestion with regard to the release of prisoners, calling attention to the traumatic effect of sudden release from a protected environment and recommends a gradual, clinically planned rehabilitation. (William L. Pious)

The Basis of Clinical Neurology. 2nd Edition. By Samuel Brock. Price $5.50. Pp. 405. Baltimore, Williams & Wilkins Co., 1945.

The new edition of this well established, authoritative textbook has been revised in several details so as to include the more recent knowledge of neurophysiology. Three new sections have been added: the first is on electrodiagnostic methods for determining neuromuscular status, and the second on physiology of urination and cystometry. This latter subject, which has been inadequately presented in previous texts, receives a clear summary here. The third section is on electroencephalography and is necessarily limited by the scope of the book.

If used as a preliminary to the study of clinical neurology, this book will make the subject a great deal more simple and rational, while for the neurologist it is an admirable review of basic information. (Maimon Leavitt)

The Psychoanalytic Study of the Child. Volume 1. Edited by Otto Fenichel, et al. Price $6.00. Pp. 423. New York, International Universities Press, 1945.

This is the first periodic publication in English dealing with psychoanalysis as applied to childhood. The annual is partly written by authors who live in the United States, partly by authors living in England, though in many cases these are not their original countries. The reader gets an interesting impression of cultural impact upon minds coming from the same spiritual tradition. The English authors (whether Viennese till 1938 or not) are in the main continuing the line of their pre-war thinking. Their discussion, their polemics are essentially intra-analytic. Methods for the study of the child other than analysis, are given only slight attention. Conceivably this "isolationism" is functionally related to the still modest position that analysis occupies as an opposing minority in the scientific field in Europe. At any rate, in the United States where analysis has won more widespread recognition, the spiritual climate has changed significantly. There is a vigorous effort going on to reach common ground and understanding with other schools of psychology, and other branches of science such as sociology and anthropology.

This volume contains at least a dozen very remarkable papers on problems of genetics, child analysis and child development, guidance work, education, and group life. (Paul Bergman.)

Trauma of the Central Nervous System. Proceedings of Association for Research in Nervous and Mental Disease. Price $8.00. Pp. 679. Baltimore, Williams & Wilkins Co., 1945.

This book represents the best thinking and experimenting on the subject of central nervous system trauma. Since an understanding of neurophysiologic and neurohistologic changes is essential for a complete clinical understanding of central nervous system injury, the emphasis these aspects of the subject receive in this book is distinctly in order. A re-arrangement of chapters so that various aspects of one subject are discussed in sequence would make it easier for the reader to follow. Attention is specifically called to the discussions following each chapter, which often contain as much "meat" as the chapter itself, as well as pointing out controversial points.

Although difficult to read straight through, this is a valuable and fascinating reference book which should be included in the libraries of all who have any dealings with or interest in central nervous system trauma. (Ruth I. Barnard.)

The Yearbook of Psychoanalysis. Volume 1. EDITED BY SANDOR LORAND. Price $10.00. Pp. 370. New York, International Universities Press, 1945.

This is a new publication of psychoanalytic works intended to be of interest to a larger public. In the future the Yearbook will cover only current contributions to the scientific progress of psychoanalysis. This volume contains about thirty reprinted papers on a wide variety of subjects that were originally published between 1942 and 1945. The papers in their unevenness of approach and method, some representing "classic" and some "modern" psychoanalysis, are for the most part excellent reading. In their totality they give a valid bird's-eye-view of psychoanalysis in its uneven status today. An introduction to the volume by Brill is the only reminder of the fighting spirit that characterized the psychoanalytic movement in the past. (Paul Bergman.)

BULLETIN of the
MENNINGER CLINIC

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FOREWORD

By KARL MENNINGER, M.D.

In April 1945 a Commission of five American psychiatrists—Dr. Leo Bartemeier, Dr. John Romano, Dr. Lawrence Kubie, Dr. John Whitehorn and the writer—were appointed by Brig. Gen. William C. Menninger, acting under the direction of Surgeon General Kirk, to respond to an invitation from General Paul Hawley, surgeon-in-chief of the Army Medical forces in the European Theater to make a study of certain psychiatric problems in the Theater. Upon completion of a tour of approximately 3,000 miles through France, Germany, Austria, Czechoslovakia, Luxembourg and Belgium, the Commission was sent to England where for a period of several weeks its members were guests of the British War Department. We were given an enviable opportunity to study psychiatric techniques and programs as developed by the Medical Corps of the Army, and Navy and the Air Forces. An official report of our observations was made to the Surgeon General upon our return to this country and has since then been released for medical publication elsewhere.

All the members of the Commission "fell in love" with England and its people. One of the things which impressed us most was the skillful use of the principle of group psychology and group dependency in therapeutic programs of various types. It seemed to the writer somewhat paradoxical that the British psychiatrists so generally give the credit for the original stimulus and the development of the basic principles of their work to American scientists but have carried the application of these principles much further than is common in American psychiatric practice. I make full allowance for exceptional instances of group therapy programs in this country; the fact remains that it is not as yet the preoccupation or method of preference in the leading psychiatric hospitals of America, whereas it actually is in England.

Before leaving England I asked Dr. (then Lieut. Col.) G. Ronald Hargreaves, one of the close associates and assistants of Brig. Gen. J. R. Rees who is so well known to us all, to obtain for me, if possible, a series of manuscripts from some of the men in the Psychiatric Division of the Royal Army Medical Corps. He kindly consented and the following papers represent essentially a symposium on the subject of group therapy and group psychotherapy, as used in England. These papers center about the so-called Northfield Experiment. This refers to the utilization of the civil mental hospital building belonging to the city of Birmingham by the Army Medical Corps for the treatment of approximately 800 soldiers with battle neuroses of various types for treatment by group therapies primarily. The Commission mentioned above had the great pleasure of spending several days at Northfield and seeing this work.

Unfortunately it was impossible to include a manuscript describing the use of psycho-drama, the publication of the hospital magazine and a number of other projects which form a part of the Northfield program and all of which were demonstrated to us in a very convincing way.

The Editors of this *Bulletin* are grateful to our British Colleagues for their courtesy in preparing for us these clear and stimulating reports of their work and we are proud to submit them to our readers.

THE HOSPITAL AS A THERAPEUTIC INSTITUTION

By Lt. Col. T. F. MAIN, R.A.M.C.

By tradition a hospital is a place wherein sick people may receive shelter from the stormy blasts of life, the care and attention of nursing and medical auxiliaries, and the individual attention of a skilled doctor. The concept of a hospital as a refuge too often means, however, that patients are robbed of their status as responsible human beings. Too often they are called "good" or "bad" only according to the degree of their passivity in the face of the hospital demand for their obedience, dependency and gratitude. The fine traditional mixture of charity and discipline they receive is a practised technique for removing their initiative as adult beings, and making them "patients." They are less trouble thus to the staff. Hospitals which follow this orthodoxy are usually designed for the individual treatment of the individual patient by an individual doctor, not in a real social setting, but in a state of retirement from society. So, isolated and dominated, the patient tends to remain gripped by the hospital machine even in the games or prescribed occupations which occupy his time between treatments.

Within such a setting, health and stability are too often bought at the excessive price of desocialisation. Sooner or later the patient, alone and unsupported, must face the difficult task of returning to the society in which he became unstable, and there regain social integration, and a daily sense of values and purpose. This task is no light one for a desocialized man, however healthy he may have become.

The design of a hospital as a social retreat also ignores positive therapeutic forces—the social support, and emotional opportunities which are granted in spontaneously structured communities. It is true that radical individual treatment can free the inner drives of the patient, and make him capable of full and stable social life, but it fails to give him an assured technique for full social participation—he can only learn this from the impact of society itself. Treatment of the neurotic patient, who suffers from a disturbance of social relationships, cannot therefore be regarded as satisfactory unless it is undertaken within a framework of social reality which can provide him with opportunities for attaining fuller social insight and for expressing and modifying his emotional drives according to the demands of real life. In any case the fact must be faced that radical individual psychotherapy is not a practicable proposition for the huge numbers of patients confronting the psychiatric world today. It is doubtful whether the hospital can usefully remain a building within which individual treatment is practised. Perhaps it must become a therapeutic institution.

A Therapeutic Community

The Northfield Experiment is an attempt to use a hospital not as an organization run by doctors in the interests of their own greater technical efficiency, but as a community with the immediate aim of full participation of all its members in its daily life and the eventual aim of the resocialization of the neurotic individual for life in ordinary society. Ideally, it has been conceived as a therapeutic setting with a spontaneous and emotionally structured (rather than medically dictated) organization in which all staff and patients engage. Any attempt to permit or create such a setting demands tolerance, a willingness to profit by error, and a refusal to jump to conclusions; but certain matters appear to be plain. The daily life of the community must be related to real tasks, truly relevant to the needs and aspirations of the small society of the hospital, and the larger society in which it is set; there must be no barriers between the hospital and the rest of society; full opportunity must be available for identifying and analyzing the interpersonal barriers which stand in the way of participation in a full community life.

These are not small requirements and they have demanded a review of our attitudes as psychiatrists towards our own status and responsibilities. The anarchical rights of the doctor in the traditional hospital society have to be exchanged for the more sincere role of member in a real community, responsible not only to himself and his superiors, but to the community as a whole, privileged and restricted only insofar as the community allows or demands. He no longer owns "his" patients. They are given up to the community which is to treat them, and which owns them and him. Patients are no longer his captive children, obedient in nursery-like activities, but have sincere adult roles to play, and are free to reach for responsibilities and opinions concerning the community of which they are a part. They, as well as he, must be free to discuss a rationale of daily hospital life, to identify and analyze the problems, formulate the conditions and forge the enthusiasms of group life. The patients must be free to plan and organize activities of actual hospital procedure, and thus face together problems of immediate social reality. Failures of organization, internal problems of apathy, insecurity, and hostility, as well as ordinary practical difficulties are matters for solution by the patients who own the community and create the problems.

The Psychiatrist's Role

Sometimes because he is an ordinary community member, often because of his special knowledge, the psychiatrist's opinion is sought when difficulties arise. He may attempt resolution of the interpersonal tensions creating the difficulty, by group therapy within a functional or a reflective

group, or may only identify the emotional difficulties involved and leave the solution to the patients. But he does not seek *ex cathedra* status. Indeed he must refuse any platform offered to him, and abrogate his usual right to pass judgment on inter-group claims or problems. The psychiatrist has to tolerate disorder and tension up to the point when it is plain that the community itself must tackle these as problems of group life. In the case of individual behaviour (for example, in men with depression) he may have to wait for a social regression to be worked through and for spontaneous reparative drives to make their appearance, or for the patient to ask for insight into his disturbance or behaviour.

The psychiatrist is ready to re-define a practical problem in terms of attitude or relationships, to reorientate another, illumine a third, and in a fourth to act as a catalyst for social response and awareness. His role as a technician among, rather than a superintendent of, his patients certainly does not mean that he can remain inactive. He should be a sincere commentator and participant in many of the social fields that wax and wane with the varying needs of the fluid population of the hospital, and be prepared to create conditions for the exercise of growing drives and interests or to open channels of communication between certain social groupings. He should be active in providing opportunities for therapeutic intercourse between patients and in modifying the practical barriers of time and geography standing in the way of this. His daily work is to study and facilitate the growth of the social pull and push which allows the isolate to expand in social integration to the therapeutic end of rich social and industrial life relating to the real community in which the hospital is set.

It must be pointed out that the medical man, educated to play a grandiose role among the sick, finds it difficult to renounce his power and shoulder social responsibilities in a hospital and to grant sincerely to his patients independence and adulthood. But it is no easier for the rest of the staff. It is difficult to live in a field undergoing internal stress without wanting to trade upon authority and crush the spontaneity which gives rise to the stress, to demand dependence and to impose law and order from above. Such measures however, do not solve the problem of neurosis in social life, but are a means of evading the issue.

Relations of the Staff

The members of the staff, too, have their problems, their fear, so to say, of the social id, and they have their own emotional needs. Group discussions, (as described in the following papers) held about specific problems, among those who are involved by them, and the exposure of the individual to the social suction and pressure in group meetings of patients and staff discussing matters relating to their daily work, are necessary to prevent the growth of

the barriers which exist between patients and staff in most hospitals. The nursing staff, the kitchen and administrative staffs, the social therapy staff, the psychiatrists, and patients all have sectional and inter-related problems in immediate practical fields and involving interpersonal and inter-group tensions. The granting of social significance and effect to the daily lives of the staff and their integration with the whole hospital community and its purpose, general and in details, is helped by routine meetings, social occasions and by participation in group therapeutic sessions. Apart from the resultant increase in sincerity and social health gained by the extension of the social boundaries of the staffs within the hospital, the effect on "atmosphere" is very important. And only thus can the whole community engage continuously upon its aim of adapting to the needs and problems of its participants.

Individual Needs

Attention to the hospital as a therapeutic community does not, of course, preclude attention to the individual problems of its members. Rather, with the recognition of the legitimate aspirations of others, an increasing provision is freely made by the community for individual limitations and needs. One group of patients, which called themselves "The Co-ordination Group" set up office and prepared to cater on demand to needs in real life which were not provided otherwise by the hospital; they specialized in unusual requests, or in seeking out jobs to suit a patient and in seeking patients to do certain jobs.

Again, the psychiatrist will give individual attention to those whose problems are not being satisfactorily solved within the various therapeutic social fields created in the hospital. The man whose social capacity is too low to allow him participation in a group activity even of "low tension" is free to choose solitary activities; and where his desire is to avoid society and activity, he will be given a single room and permitted to do nothing. For despite the basic conviction that it is no part of the function of a hospital to compel a compulsory retreat from society in exchange for treatment for all those who enter its doors, there are many patients whose best immediate relationship with society is isolation, dependency or personal regression.

Northfield provides facilities to meet these occasions; men mourning the loss of their comrades in battle are given full facilities to carry out this social task; a darkened ward and continuous narcosis is available for those who express themselves by symbolic illness as being in need of a period of infantile behaviour; the man with problems of aggression may be granted a job involving satisfactions for his aggression; and the cynical may receive the support of the personal transference situation until he is able to accept life in a small group of chosen friends. When acute needs have been

satisfied, however, these patients are faced with a wide range of social and industrial opportunities, and are free to move at their own choice and at their own speed within the social fields which best suit them. As every social field is connected by emotional channels with others, the patient thus embarks upon life in a real society which can continue up to a limit, to allow him an expansion of his social relationships. This limit is not set by hospital boundaries, for he may work and form relationships within the wider geographic boundaries set by modern forms of travel.

The Aim

The socialization of neurotic drives, their modification by social demands within a real setting, the ego-strengthening, the increased capacity, sincere and easy social relationships, and the socialization of super-ego demands, provide the individual with a capacity and a technique for stable life in a real role in the real world. The common remark made when a patient is asked on leaving why he is better, is a vague "I don't know why. I found something that suited me. Then I met some nice people. I think that helped." The psychiatrist is rarely mentioned as a therapeutic agent, and where he is highly praised, this is regarded as a failure of therapy. For with increasing social and industrial vectors from the larger society outside the hospital there should be no regrets on leaving; rather an increased zest for life and confidence that the problems it presents can be met and faced without inefficiency or unhappiness.

THE NORTHFIELD EXPERIMENT

By Major H. BRIDGER, Royal Artillery

For the past eight months an attempt has been made to examine how far a continuously changing population of patients and staff could develop its own form of community within the framework of a Military Psychiatric Hospital of 800 beds. It would be impossible in a short article to describe or trace the everchanging scene in detail; on the other hand it would be misleading to discuss one facet of the experiment unless considered within the context of the whole. That aspect of neurosis which is social cannot be isolated from the rest, and certainly cannot be treated solely by a Social Therapy Staff. The "departmental" approach would be as unreal as the treatment of an individual without relation to the societies in which he has lived, is living and will live. Nevertheless in the same way as an administrative staff would serve a community by helping it to function from within and without, so a social therapy staff can play its part in providing opportunities and channels for the development of the community's needs.

Program of Admission

The large majority of men coming into the Northfield Hospital say "I am browned off with everybody and everything," "I am fed up with the Army," "I seem to have lost confidence in myself" or "I hate being pitied" and so on. Let us trace the progress of such a man at the present time. He enters the Admission Ward in the company of a few others and they are met by the nurse and a group of patients whose selected activity it is to act as receptionists and guides in the fullest sense. After the first initial allotting of beds, etc., they are joined by the psychiatrist attached to the Admission Ward. They are each handed a program of their first three days' stay (which entails remaining in this ward), and copy of a magazine produced by the patients called "Introducing you to Northfield." They are asked to read it, discuss and ask any questions they like. The receptionist group deals almost entirely with this, and then splits up to take small numbers of newcomers on a tour of the Hospital, so that the contents of the magazine become a living organism.

They visit the Hospital Club which is run entirely by patients who have selected this as their "activity," they see patients working on the newspaper in their own offices, the band practising for dances and socials, men painting scenery and arranging lights for stage shows, gardens and gardeners, a tennis court in use, the sports facilities, building construction and the Selected Activities yard, where painting, sculpture, handicrafts of all kinds, carpentry, radio construction etc., are all taking place. They see

and enter the ever-open doors of contact officers, welfare workers and so on who are there to help them at any time.

More important still, they see each as a living part of the total pattern and hear what their guides and others have to say about it, spontaneously and in answer to their questions. They hear from the patients that this is part of treatment. They see and hear, for instance, that in the Selected Activities Yard, while each patient is making something for his wife, child or for himself that there is an overall project by which individuals and small groups are providing toys, accessories and fixtures for Child Guidance Clinics and Nursery Schools. They learn that from these activity huts one can 'graduate' to become a member of small groups, each of which has its own circuit of nursery schools to maintain, by mending toys and re-decorating the playrooms (incidentally helping the nurses to bath the babies!).

"But," one or more men will say, "I am not interested in any of this; I am interested in engineering, farming, poultry-keeping, plumbing. . . ," as the case may be. His guide tells him that when he meets his psychiatrist and the Activities Officer he can arrange to conduct his activity at the Austin Motor Company, the Avoncroft Agricultural College and so on, where special facilities are available for them to take part in the life of these communities. Space does not permit further description, but sufficient has been said to show that the man returns to the Admission Ward, despite all other considerations, with a sense of security in his surroundings. This is now helped further by short individual interviews with the senior psychiatrist and then by meeting his own psychiatrist for his initial interview. The activity is selected between them and should it need special arrangement, the patient is interviewed by the Social Therapy Officer concerned, who immediately, in the fullest sense, makes the man a partner in achieving his particular objective. Many men use the activity selected as a test for the psychiatrist and social therapist, or they may use it to test themselves in a real or fantasy role. Particularly is this true of the returned P.O.W. who wishes to have a "farm," and "cottage in the country" or "help to look after horses" etc.

Selection of Activities

It is interesting to note at this point that, whereas eight months ago the new patient would say that he did not want to do anything while in the hospital, and the "older" patient would describe the limited range of activities as jobs to "occupy his mind" or "occupy the time between interviews", each now accepts the activity, *selected by himself* in conference with his psychiatrist, as a recognized part of his treatment. The term "occupational therapy" had contributed to this older conception and is no longer used here; the main factor however, was the limited scope allowed by

orthodox occupational work. The free extensive range and principle of joint selection gives the man every opportunity to satisfy needs or urges. The soldier not infrequently says "I have always wanted to try my hand at . . . but I don't suppose you can do anything about that":

That he is a real partner in achieving the opportunity is a vital matter. This does not mean that all new patients immediately settle down to following their activities with enthusiasm and keenness, or that they will even do so regularly after a few days. The fact that he wanders off for walks on his own or with a friend is information for the psychiatrist, the nurse, the social therapy staff and the men with whom he is working; each deals with the situation within their own overlapping fields. The patient is not 'checked' in the military sense; the social and therapeutic forces at work can safely be left to cope with the problem in a shorter or longer time—he will find his place and activity in a little while, even if he changes the latter two, three or more times.

Recreation

For the rest of his stay in the Admission Ward the man spends his time being "re-kitted," completing questionnaires and psychological tests. In between times and in the evenings he revisits one or more of the places he has already found attractive—the N. A. A. F. I. (Canteen) where he can obtain refreshments and buy any necessary small items he requires, the Club where table-tennis, darts, billards, etc., are always in progress and where in another room he may be drawn into playing in a Whist Drive (bridge tournament) or the gymnasium where a play, variety show, dance or film is taking place. The notice-board in his ward always tells him what is "on"; his host-patient may however bring some of this to his notice or may invite him to join a party going to a dance, theatre or social run by members of local firms, clubs or societies, where he can meet men and women who are having fun, and not just giving him a "good time". In some cases these are the first steps in an England which he may have left three, four or five years ago. The decision is at all times left to him; the opportunities are there and are offered with an encouragement to accept, but his wishes are respected and understood by his fellows.

Introduction to the Treatment Ward

On the afternoon of the third day he is introduced to his Treatment Ward, which is in charge of his psychiatrist and nurse. The ward-workers group (whose selected activity is to look after all domestic affairs in the ward) will 'put him wise' to everything going on. The ward committee members are soon giving and receiving information and their section of the notice

board becomes a focal point. He realises that he will be a member of the ward for the rest of his stay in hospital, and he can now embark on a secure but flexible program, involving not only the life in his ward and his selected activity, but also the social opportunities inside and outside the hospital.

Every day his psychiatrist sees him during the morning round, each week the Commanding Officer of the Hospital makes his inspection and is ready to hear requests and complaints. In addition, the ward holds its own weekly meeting which is attended by the psychiatrist and nurse. The men elect their own chairman who, together with two other elected representatives, attend a full meeting of Ward Committees each Friday. These meetings, on "constituency" and "House of Commons" levels, are extremely useful conductors by means of which domestic and hospital tensions can be transmitted and resolved. Matters affecting the ward are dealt with by the "constituency"; matters bearing on hospital affairs are referred to the "House of Commons". The latter meeting is attended by the Commanding Officer and the senior officer of the Social Therapy Staff, who act as links, should it become necessary, with all hospital departments, any member of which has a standing invitation to attend.

Self-Government

Despite the continual ingress and egress of patients, it is possible, through the growing volume of committee meeting minutes, to trace the trend of a society developing in almost direct proportion to a growing sense of achievement and responsibility. The history and analysis of these meetings would need more than an article for themselves. At the beginning it was a collection of individuals, most of whom were self-appointed ward representatives, airing personal grievances and grumbles. Now it is a constitutional body quite conscious of its value and responsible to the community, considering at this moment plans for a total hospital project related to building an extension to the Crippled Children's Hospital in Birmingham. Its sub-committees deal with dances, socials, the Hospital Club, sports and competitions of all kinds; its meetings are attended by a representative of the newspaper group and reported weekly. The human day-to-day problems of the community are reflected in the discussions and cover every type of problem and every hospital group whether patients or staff.

Its work is not bound by the confines of the hospital. The links between the Northfield community and the city (Birmingham) community are becoming more numerous and more clearly defined. The growing contacts opened up by Selected Activities, sports and parties have brought large

industrial concerns well within the community consciousness, with the result that its psychological as well as geographical field has widened to an extent which tests both Ward and Committee meetings to the full.

The Social Background

It is in relation to this background, the frame of reference set up by the social life of the ward and hospital community, that each psychiatrist has the opportunity of treating his patients, individually and in groups. This frame of reference changes imperceptibly but surely as time goes on, but it has a value which has taught us much. It is more than interesting for a psychiatrist to see how the cohesive and disruptive forces react on the member of his ward in relation to domestic and hospital matters. He can observe behavior which will be of the greatest value in treatment.

So far little has been said of other functional groups within the hospital, but they each have their role to play, not only in maintaining the hospital services and administration but in a contribution to the total community. The women's services in particular take a full and essential share in the social life of the hospital. It may well be said that the Social Therapy staff of a hospital is the whole staff together with the whole of the neighboring population. One can be tempted to add that unless this is so, treatment is limited and may even be sterile. The treatment (one may call it an education in sincerity and tolerance if one wishes) which the patients have given to all related groups must also be an important consideration.

Although it is not possible here to trace in detail either the phenotypical picture of development or the process of 'Lewinfiltration'* (our term for describing the dynamics of the growth of a community pattern), some conception of its progress can be educed by considering first the field existing just prior to the beginning of the experiment and second, the initial rearrangements of bounds.

Without describing the previous social structure of the hospital, it will be sufficient for the purpose to say that entertainment, recreation, education and 'occupational therapy' were extra-responsibilities for three different psychiatrists. 'Rehabilitation' in the hands of a military staff, which dealt only with patients in the last two or three weeks of their stay in the hospital consisted mainly of para-military training.

Development of the Community

By mutual arrangement with the unit concerned, the function of the 'Training Wing' was delegated to the Convalescent Depot through which most patients passed who were returning to the Army. The new Social Therapy Staff then undertook responsibility for all the other branches of

* Reference is here made to the work of Dr. Kurt Lewin, of America, in group dynamics.

social life in the hospital, although well aware that it was quite inadequate to deal with the situation alone. There is no doubt that from one point of view at least, this could be considered a great advantage! With the co-operation of the Commanding Officer, administrative alterations were made to allow one large ward to be left vacant for a Hospital Club. The one selected was that adjacent to the Admission Ward. The side-rooms in the corridor leading to the Club entrance were taken over to allow for any demands which might be made upon them. Using the accepted term at the time, a new 'occupation' was opened—a hospital newspaper group. A few interested volunteer patients began with a duplicating machine, accessories, paper—and a debt for the initial outlay of $260.00. At the same time all wards were asked to send two representatives to a meeting in the empty "Club." Although only half the wards were represented, discussions began on the basis of these elementary changes. These meetings continued, supported weekly by a few stalwart patients but it was some weeks, and in some cases, months, before wards were holding regular ward meetings. This did not prevent the committee and the newspaper group from trying other approaches, and gaining ground in the development of activities and Club facilities.

In conclusion, some general remarks must be made, briefly and specifically, in relation to the Social Therapy Staff. Such a staff must be flexible in its structure, sincere and tolerant in its approach; must become quickly aware of problems arising, the psychological and physical barriers which exist or are being set up, and the forces which are being brought into play. It must be prepared to have the courage and patience required in making the primary decision relating to the resolution of inter- and intra-group tensions; is a particular situation one to be left with and faced by the groups or group, or should links be established when there are internal or external factors preventing their formation?

We have learned that the individual must be given every opportunity to develop his own sense of responsibility and inner discipline by gaining a social insight, an awareness that his freedom within the community depends on his interpersonal relationships and a feeling of "belonging." To this end the project method of instruction has proved invaluable and much has been done by emphasizing that reports on patients for the information of psychiatrists should be in socio-behaviorial terms.

Finally, for all groups, whether founded spontaneously or not, whether large or small, it is true to say that the individual contribution has a value only in so far as it has a significance to the community; it is equally true to say that the individual can only experience full freedom and satisfaction in a society that recognizes his worth, and gives him the opportunity to develop in a spirit of warm human relationships.

THE LEADERLESS GROUP PROJECT

By Major W. R. BION, R.A.M.C.

When the War Office Selection Boards were set up it was believed by many that both the supply and the quality of officers was falling off and must continue to fall off as the war went on. There was certainly very little doubt that that belief was true in so far as it referred to the past. But as the senior psychiatrist called in to advise on selection and methods of selection, I pointed out that there was no reason why this statement should be regarded as an axiom. It could be maintained that in a nation at war the supply of leaders could be made to increase and their quality, thanks to the compulsion of national need, could be made to improve. For this to happen selection of candidates would have to be at least as careful as the selection, in forestry, of trees to be converted to timber.

The proposals put forward to bring this state of affairs to pass, over the whole field of selection and not merely at the War Office Selection Boards, were rejected and need detain us no longer. It became necessary to confine our activities to the selection of candidates from among those who appeared at the Boards.

Technique of Selection

The essence of the technique which was evolved, and which has since become the basis of selection techniques in many different fields, was to provide a framework in which selecting officers, including a psychiatrist, could observe a man's capacity for maintaining personal relationships in a situation of strain that tempted him to disregard the interests of his fellows for the sake of his own. The situation had to be a real life situation. The situation of strain, and the temptation to give full rein to his personal ambitions was already there; the candidate arrived prepared to do his best and get himself a commission and, naturally, he feared the possibility of failure. Furthermore this was a real life situation. The problem was to make capital of this existing emotional field in order to test the quality of the man's relationships with his fellows.

This was done by a method so simple and so obvious, when it has been propounded, that its revolutionary nature can easily be lost sight of. The man found he was not entered in a free-for-all competition with other candidates. Instead he found himself the member of a group and, apparently, all the tests were tests, not of himself, but of the group. In concrete terms, a group of eight or nine candidates, an "eye-full" from the testing officer's point of view, was told to build, say, a bridge. No lead was given about organization or leadership; these were left to emerge and it was the duty of

the observing officers to watch how any given man was reconciling his personal ambitions, hopes and fears with the requirements exacted by the group for its success. That, in brief outline, is the basic principle of all the Leaderless Group Tests.

A little consideration will show that the situation thus created is very closely parallel with countless other emotional situations in an officer's life, not even excluding action. For though the emotional tensions in this situation are low compared with those in battle they are nevertheless sufficiently powerful to make all candidates feel that their time at a War Office Selection Board has been a heavy strain despite the interest of the experience and the apparently easy program. It was found that if the testing officers watch what they are meant to watch they have no difficulty in matching what they have found out about a man's personality with what they know will be the sort of job with which he will have to cope as an officer.

It is safe to say that nearly all mistakes arise through failure to keep the selecting officers mindful, throughout all the tests, of the very simple basic principles mentioned above. Either officers tend to interfere, and so distort the field, or else they watch how well the group does any given task. It is important to insist that the actual task of the test is merely a cloak of invisibility for the testing officers who are present; an artificiality intended to explain, and therefore to explain away, the presence of the testing officers. It is not the artificial test, but the real life situation that has to be watched, —that is, the way in which a man's capacity for personal relationships stand up under the strain of his own and other men's fear of failure and desires for personal success.

Parallel Situation in the Psychiatric Hospital

The difficulty which is experienced in teaching officers to watch the real life situation in these selection procedures is unhappily met again in psychiatric hospital practice. An observer with combatant experience could not help being struck by the great gulf that yawned between the life led by patients in a psychiatric hospital, even when supposed to be ready for discharge, and the military life from which their breakdown had released them. Time and again treatment appears to be, in the broadest sense, sedative; sedative for doctors and patients alike. Occupational therapy meant helping keep the patients occupied—usually on a kindergarten level. Some patients had individual interviews; a few, usually the more spectacular, were dosed with hypnotics. Sometimes a critic might be forgiven for wondering whether these were intended to enable the doctor to go to sleep.

It thus seemed necessary to bring the atmosphere of the psychiatric hospital into closer relationship with the functions it ought to fulfill. Un-

fortunately for the success of any attempt to do this, psychiatry has already accepted the doubtful analogy of physical maladies and treatments as if they were in fact similar to neurotic disorders. The apparatus of the psychiatric hospital, huge buildings, doctors, nurses and the rest, together provide a magnificent smoke screen into which therapists and patients alike disappear when it becomes evident that someone may want to know what social function is being fulfilled, in the economy of a nation at war, by this aggregate of individuals.

It must of course be remembered that in a psychiatric hospital there are collected all those men with whom ordinary military procedures have failed to cope. In this brief account it is not necessary to recapitulate in detail the steps taken to deal with this situation. They have already been described elsewhere. But, briefly, it was essential first to find out what was the ailment afflicting the community, as opposed to the individuals composing it, and next to give the community a common aim. In general all psychiatric hospitals have the same ailment and the same common aim—to escape from the batterings of neurotic disorder. Unfortunately the attempt to get this relief is nearly always by futile means—retreat. Without realizing it doctors and patients alike are running away from the complaint.

Group Discussions

The first thing then was to teach the community (in this case the Military Training Wing) to seek a different method of release. The flight from neurotic disorder had to be stopped; as in a regiment, morale had to be raised to a point where the real enemy could be faced. The establishment of morale is of course hardly a pre-requisite of treatment; it is treatment, or a part of it. The first thing was for the officer in charge not to be afraid of making a stand himself; the next to rally about him those patients who are not already too far gone to be steadied. To this end discussions were carried out with small groups. In there the same freedom was allowed as is permitted in any form of free association; it was not abused. These small groups were similar in organization and appearance to the Leaderless Group Tests, known as group discussions, which had already been used, though for a different purpose in the W.O.S.B.

As soon as a sufficient number of patients had in this way been persuaded to face their enemy instead of running away from it, a daily meeting of half an hour was arranged for the whole training wing, consisting of between 100 and 200 men. These meetings were ostensibly concerned only with the organization of the activities of the wing. The wing by now had been split up into a series of voluntary groups whose objects varied from learning dancing to studying the regulations governing army pay. In fact the problems

of organization, of course, hinged on the problems of personal relationships. Lost tools in the handicraft section, defective cinema apparatus, permission to use the local swimming baths, the finding of a football pitch, all these matters came back to the same thing, the manipulation and harmonization of personal relationships. As a result almost immediately these big meetings as well as the small ones, spontaneously became a study of the intra-group tensions and this study was established as the main task of the whole group and all smaller groups within it.

Study of Tensions

Thus occupational therapy had been given a new meaning. The therapeutic occupation of the group was the study of the tensions within itself. It was not basket making, or learning to swim, or carpentry, or studying army pay, even though such activities might, and often did, bring relief.

It was a result of this therapeutic activity that the group began to think, and a deputation voiced the thought, that 80% of the members of the training wing were "skrim-shankers," "work-shys," malingerers and the rest, and ought to be punished. A month before the training wing had complained indignantly that inmates of a psychiatric hospital were regarded by the rest of the community as being just these things. It was disconcerting, but a revelation of what psychiatry could mean, when the psychiatrist refused to accept this wholesale diagnosis, and simple proposal of punishment as the appropriate form of therapy, as a sound solution of a problem which has troubled society since its commencement. The therapeutic occupation had to be hard thinking and not the abreaction of moral indignation. Within a month of the start of this metier these patients began to bear at least a recognizable resemblance to soldiers.

Guiding Principles

Throughout the whole experiment certain basic principles, believed to be absolutely essential, were observed. In order of their importance they are set down here even though it involves repetition.

1. The objective of the wing was the study of its own internal tensions, in a real life situation, with a view to laying bare the influence of neurotic behavior in producing frustration, waste of energy, and unhappiness in a group.

2. No problem was tackled until its nature and extent had become clear at least to the greater part of the group.

3. The remedy for any problem thus classified was only applied when the remedy itself had been scrutinized and understood by the group.

4. Study of the problem of intra-group tensions never ceased—the day consisted of 24 hours.

5. It was more important that the method should be grasped, and its rationale, than that some solution of a problem of the wing should be achieved for all time. It was *not* our object to produce an ideal training wing. It *was* our object to send men out with at least some understanding of the nature of intra-group tensions and, if possible, with some idea of how to set about harmonizing them.

6. As in all group activities the study had to commend itself to the majority of the group as worth while and for this reason it had to be the study of a real life situation.

The Psychiatrist's Problem

One of the difficulties facing a psychiatrist who is treating combatant soldiers is his feeling of guilt that he is trying to bring them to a state of mind in which they will have to face dangers, not excluding loss of life, that he himself is not called upon to face. A rare event, but one that does occur, is when an officer is called upon to stop a retreat which should not be taking place. His prominence at such a time will certainly mean that he will be shot at by the enemy; in extreme cases he may even be shot at by his own side. Outside Nazi Germany psychiatrists are not likely to be shot for doing their job, though of course they can be removed from their posts. Any psychiatrist who attempts to make groups study their own tensions, as a therapeutic occupation, is in today's conditions stopping a retreat and may as a result be shot at. But he will lose some of his feeling of guilt.

In conclusion it must be remembered that the study of intra-group tensions is a group job. Therefore, so long as the group survives, the psychiatrist must be prepared to take his own disappearance from the scene in not too tragic a sense. Once the rout is stopped even quite timid people can perform prodigies of valour so that there should be plenty of people to take his place.

THE TECHNIQUE OF GROUP THERAPY

By Capt. MILLICENT C. DEWAR, R.A.M.C.

Before entering upon any description of the technique of Group Therapy we must study the different ways in which a group may be formed. We have firstly those of the patients who have been admitted together and formed into a group from the beginning with or without individual therapy and secondly there are those formed after some individual therapy; these are "closed groups" in that no new patients come in after the first session and the group breaks up when they are discharged from the hospital. Thirdly, there is that group which may be termed "open" in which patients are continually coming in and going out, thus giving a continuity of the group but not of the participant individuals. This last type is the least typical but has often to be used, as the admission and discharge rate cannot tolerate the rigidity of the first two methods. Most patients are suitable for group therapy but although in this stage of our experience it would be difficult to lay down arbitrary rules, the following do *not* appear to be so: the very depressed, who in an experimental group showed that the essential disintegrating qualities of their aggression broke it up; and those who are mentally dull and find it almost impossible to verbalize their thoughts.

Preliminary Arrangements

The actual handling of a group is difficult to describe. It must of necessity vary from psychiatrist to psychiatrist and can have no rigid doctrine applied to it. It has been found best to have the men in a smallish room sitting in as near circular formation as possible. This would appear to create the optimum situation for exchange of feeling and ideas. Group sessions running coincidentally with individual therapy are usually held once a week but where they are the only form of treatment they are run twice or thrice weekly.

The beginning of the first session can be attempted in different ways. The patients may be told beforehand that they will discuss their personal problems as freely as possible, or without any previous preparation they may be put together and in the first meeting challenged by the psychiatrist. To my mind the ideal group is one in which patients have been admitted together and have worked as a group from the beginning; they are immediately confronted with the problem of discussion and have the minimum of individual contact with the psychiatrist.

The Function of the Psychiatrist

The next matter for consideration is the rôle of the psychiatrist, who inevitably has a different function from that of other members of the group.

He holds in their eyes a position of authority and they to him are inevitably patients. It is essential, however, that his interest in them must be directed to the group and not toward the individual in the group. That is to say, the ordinary psychiatrist-patient transferance situation must be at a minimum, otherwise from time to time it cuts out members and so disintegrates the "group feeling."

There is usually difficulty at a first meeting, for the patients are unfamiliar with the situation and the psychiatrist is confronted with his first problem; an uneasy tension slowly rises and he must decide how long he should allow it to go on. In our hospital where patients never stay longer than three months and usually a shorter time, it is our practice to break the tension after an interval of about five minutes. If it is not broken soon, deep unconscious trends begin to emerge with which in the short time at our disposal it might be difficult or impossible to deal.

In the main the breaking of the tension may be done in one of two ways; the psychiatrist may throw in a controversial remark or he may query the actual silence itself. This usually starts a flow of superficial talk, and in early sessions the general rule is to allow the conversation to remain on this level so that the patients get to know each other; the next session opens with a consequently lower group tension. There are, however, exceptions to this rule which illustrate the fact that the prime moving force in this is in the group itself. (Recently a group treated from the beginning as one, brought out at their first meeting deep feelings of guilt about having been taken prisoner of war. They have since returned to it at other sessions and have gained a great deal of insight into the problem. This depth at a first meeting is, however, rare.)

As the sessions go on the group usually tackles more personal and complex problems and the degree to which it does this is most impressive and satisfying. It is common to get a man who has no insight whatsoever into his own problems solving others similar to his own in another member of the group. When this has gone on for some time the psychiatrist may put in a pointer to illuminate the situation which has developed between the two men.

Therapeutic Guidance

The psychiatrist should help to bring out of many remarks and trends of conversation some central guiding principle and conclusion. Where for instance a general drift of conversation has been going on about the generally bad characteristics of sergeants and officers, the dislike of rules and regulations, a word or two would be needed as to the underlying cause for this general dislike of authority and authoritarian figures.

It cannot, however, be emphasized too often that the psychiatrist must

not dogmatize or dominate his patients. If he is too eager to speak the group immediately becomes an audience and their peculiar inter-personal relationships are destroyed. This should not blind him, however, to the times when his comments can be powerfully therapeutic for the group. Occasions arise in a group meeting where the arguments begin to go round in ever widening circles and a feeling of distress and insecurity can be felt to rise within the group because they see no hope of any conclusion being reached. Here it is essential that the psychiatrist accept responsibility as a parental figure and makes his presence felt by giving an explanation, a word of reassurance or even a word of ridicule. This at once restores a sense of group security and the patients are able to go on with the search for a solution of their problems.

Problems of Assimilation

Some more specific situations are caused by the man who sits silent. It is better to allow the group itself to treat this man for almost invariably they will bring him into the conversation. If, however, they do not manage to do so after several sessions, it is necessary for the psychiatrist to draw him in by some remark addressed to him, in relation to the rest of the group. There is also the problem of the anti-social or schizoid person in the group who is turned upon by the other members. The psychiatrist must in this instance probe the rest of the group as to the reason for their attitude to this man. Otherwise in a case like this the group is merely playing the part of a rather stern jury with very little understanding and is not therefore therapeutically helpful to the man.

There is much that might be said, but in a short article the main point which needs stressing is that the psychiatrist should play a "passive" undidactic rôle, easing tensions and interpreting in a way determined by the emotional needs of the group.

PRINCIPLES AND PRACTICE OF GROUP THERAPY

By Major S. H. FOULKES, R.A.M.C.

Instead of sitting alone with one individual patient, the therapist may call a number of them together and talk to them. In a military hospital, for instance, there are many things which he may wish to convey to all his patients together, or to a whole ward. In such a situation he would talk differently than when talking to a patient alone. At the same time, if encouraged, they will talk back and also to each other.

One of the first things the therapist will notice is the general atmosphere. His patients may appear obediently or curiously expectant, bored and apathetic, good humored or tense with anxiety, adversity and hostility. The conductor will become aware of their predominant attitude towards himself. He will sense, for instance, whether and in what way his presence influences the picture. This may be due to the sort of person he is, what he may or may not do, what he has to say and how he says or does it. He will be observed by the group, scrutinized and summed up, quickly and precisely, as by common consent, yet by intangible ways of perception and communication.

Meanwhile his own observation of the group becomes more detailed also. The patients are not a uniform body. Sometimes they are in good agreement, sometimes sharply split and clashing over an issue only to march in perfect unison a few minutes later. They may be with him, or against him. Many of them stand out from the main body, and gradually all of them acquire individual characteristics. Some are absent altogether and others keep out of range choosing their seats behind the therapist: Some sit aside in isolation; some are at ease while others are tense and preoccupied. Some are attentive while others talk, and here and there is a man persistently unconcerned about what is going on, while another is restless and fidgety. A man, sitting in a corner, suddenly, as if awaking from sleep or out of a dream, makes a sarcastic remark or voices violent opposition, or shoots off at a tangent; another, who had not spoken yet and remained undefined, unexpectedly sums up a whole discussion humorously, follows this up by one or two constructive proposals and alters the whole situation.

The Group Functions

The psychiatrist listens and mentally registers. His "patients" have become alive, acting in a reality which he can share with them, under his own eyes. He need no longer rely on their own accounts and descriptions, based on self-observation and introspection, with all their fallacies, but can see for himself how they behave, feel and react, where they fail or are ham-

pered by their disturbances. If he is in a position to check this against other observations, he can convince himself of the significance and reliability of this display. He is then fully justified in attaching importance even to the smallest detail observed. Frequently a patient shows up quite new facets, which the psychiatrist can follow up with further observation and inquiry.

Thus a first contact is established. It is a mutual contact. The therapist need not be afraid of this searching test, unless he could be credited with bad intentions. All he need be is honest. Pretence and acting would not go far. Nor is there need for them for the group psychotherapist is not concerned with making a good impression, with being liked or disliked. By this first mutual contact a community of feeling has been experienced by the patients among themselves, as well as in relation to the therapist, and in addition embracing the whole little community, therapist and patients together. The importance of this cannot be overrated. While in itself a potent therapeutic agent, in particular against a background of the usual pre-existing apprehensions and misapprehensions, it is the indispensable matrix for other therapeutic steps. If the therapist is open and sensitive to this contact, meets his men more often and regularly in this way, he can learn to play on them at will, as on an organ, and could on this basis alone lead them almost anywhere, if that were his task.

The Art of Leadership

This, however, is not his task in a psychiatric hospital where the patients' difficulties are essentially of such a nature as to prevent them from standing on their own feet and grappling with their own problems. If the psychotherapist resists the temptation to be made a leader, he will be rewarded by their growing independence, spontaneity and responsibility and personal insight into their social attitudes. It happens in exact proportion to the psychiatrist's art of making himself superfluous. He can, however, resign only from something which he is strong enough to possess, and if there are doubts as to his capacity for leadership, he had better accept this function offered to him until such time as he is quite certain and secure in it. He must not hesitate to lead when the situation demands it.

The ward is the patient's temporary home and surround, his refuge from that strange and bewildering turmoil, the hospital. Here he meets his pals with whom he is to share the ups and downs of his present life and, more or less intimately, the experiences of the past and the worries at home, his and theirs. These are the people with whom he will talk on lonely walks and after "lights out" at night. The spirit which permeates the ward, and which the psychiatrist must foster, is thus of the utmost therapeutic significance. The ward has another function: that of a bridge between the

patient and the hospital. It occupies a definite place and has an active, responsible and powerful part to play in the hospital. As a member of the ward, the patient shares in this, he begins to realize that the hospital is his, is what he makes out of it, that he is the hospital.

The Psychotherapeutic Group

More is needed, however. The patient needs insight; insight into his own inner condition and life, insight into his present feelings, behavior and reaction. Therein lie the limitations of a large meeting (30–80 men): The patient's reactions, cannot be brought to light, voiced, described, realized or brought home to him by others. For this a more intimate setting is essential. Seven or eight people at a time have proved a good number. They meet regularly about once to 3 times a week, for a set period of 1–1½ hours, in the presence of the psychiatrist, in order to discuss anything they wish. Strong interpersonal relationships develop and features of an organismic structure become more and more evident. This type of meeting we call a psychotherapeutic group. The psychiatrist leaves the lead to the group, acting mainly as a catalyst and observer. The individual participant produces himself or his ideas for the group, acting also as receiver and audience when he takes an active interest in the others' problems.

If the conductor sees to it that each member participates as fully as possible in these various functions and does not neglect to watch and treat the group persistently as a whole as well, it will soon become a self-treating, self-propelling and progressive body. He will be better able then to observe and steer the group unobtrusively—more towards this problem or that, towards one patient or another's needs, and generally towards psychological levels which he deems desirable or for which he feels fit. In such a group the individual is thrown into high relief and the greater the psychiatrist's experience and skill, the less will he find it necessary to relegate so-called personal problems to supplementary individual interviews.

Selection Factors

No particular selection of patients is necessary for this type of group, but all sorts of selective principles can be interestingly and usefully applied. All that is desirable is to avoid too striking a disparity in such factors as intelligence, age, past Army experience and prospective disposal. It is equally undesirable to put individuals into a group who from certain factors are bound to be sharply separated from the group's other members. Where possible, a common general background is desirable. Such a group can be left "open": that is, as older patients leave the hospital newcomers take their place in the group. It is desirable that there should always be a representative number, say two-thirds, present who have been together for

at least four weeks, if continuity is to be maintained. Alternatively, once established, it can be conducted as a "closed" group, keeping its composition unchanged until disbanded. This has many advantages, especially if the same group undertakes a group project together as well, and if the time of stay in hospital is altogether short. The stronger bonds thus established outweigh the possible disadvantage of inbreeding, and weaning especially as in spirit and orientation every group should be "open."

Many of the socializing and therapeutic factors become operative in the same way in the groups which have been extensively developed at this hospital to carry out group projects. Indeed they form their essence. But unless a skilled observer can be always present with the "Selected Activity" group and report to the psychiatrist concerned, these forces operate blindly and there is not the same opportunity, as there is in the therapeutic session, to make the patients aware of what is going on.

The therapeutic session is, in a sense, a "Selected Activity" as well: that of learning to talk, express and listen to opinions, discuss matters of interest and so forth—an important social activity. The relationship and mutual penetration of these two fields of observation, artificially separated as *psychotherapy* and *social therapy*, is a fascinating study as well as of great practival importance. It could be said that a group has boundaries like a membrane of variable permeability. If the hospital milieu is opposed to the spirit prevailing in the group, if the osmotic pressure is high, these boundaries harden and become more selective; if the spirit inside and outside is in harmony, they may almost or completely disappear. This is another most important and more specific link between the hospital and the patient, and the more the hospital as a whole becomes a therapeutic field, the more can it become the main function of the psychotherapeutic group to activate and prepare the patient for the impact of the hospital community upon him and in turn to work out with him the stimuli thus received. This puts the emphasis of treatment not upon past history but upon the immediate present—a desirable shift where time is short—and one of the most important aspects of this approach.

Group Dynamics

As far as the individual is concerned in group therapy he finds himself in others and others in himself, by similarity and contrast, thereby regenerating to some extent his ego and its boundaries. At the same time the group is a potent modifier of the superego and liberator of the id, symbolizing, as it does, the community, and in the last resort being unconsciously understood by the group in its archaic significance. Group dynamics are not within the compass of this paper. They are manifold and seem to work with great precision. There is no doubt that they can be used as therapeu-

tic vectors of great potency. Much of this is still empirical and intuitive, but one cannot escape the impression of a quasi-mathematical precision, best perhaps to be expressed in terms of Field Theory.

It has been possible within this framework to assign a number of psychiatrists and practitioners, without selection and for the most part without much preparation, to groups, or rather, assign the groups to them, without doing any harm, to say the least of it. There is general agreement that it does them, as well as their patients, a lot of good. With increased knowledge, the framework becomes more and more precisely adapted to the purpose. It leaves the individual conductor free to choose a style and range of group psychotherapy appropriate to his experience, skill, and the degree of rigidity in his own make-up, etc. His approach will in any case be reflected in the group, and as he is himself thrown into the group as well, this acts as a mutually self-regulating procedure. This has helped matters a great deal, since our task at Northfield Military Psychiatric Hospital is to devise methods as simple as possible so as to be applicable as broadly as possible. A note of warning may be permitted here: not to connect "Group Therapy" as such with a notion of mass production. It is not a sausage machine! Within a different framework and with more ambitious aims, it is an instrument so delicate and yet so powerful, that its skilled handling demands more from the therapist than the most difficult individual analysis.

One of the ways in which the individual psychiatrist's position tells, is expressed in what he feels he can handle in a group or individual session respectively (and here again he will choose the right proportion for himself). Individual sessions are partly supplementary, partly antagonistic to the group, at least as long as the approach is not "wholistic" in the therapist's mind.

The writer's practice at Northfield, from considerations both of experiment and expediency, has been increasingly towards putting the group into the center, even in the individual interview where necessary, and shifting the emphasis from the smaller group of the consulting room towards the ward and the hospital as a whole, and in the last resort—from all levels—towards the community. This was possible since the hospital as a whole became more and more a therapeutic field and since he knew that, while digging a tunnel from one end, he would be met halfway by workers from the other end—in other words, that the general hospital activities were directed with the same basic idea and identical intentions.

NOTES ON A GROUP OF EX-PRISONERS OF WAR

By Major SUSAN DAVIDSON, R.A.M.C.

These notes of the progress of a group of ex-prisoner-of-war patients at Northfield Military Hospital are given in the manner in which they were recorded and without censorship or comment. They were compiled from memory after each group meeting.

This group of N.C.O.'s was selected by the psychiatrist who referred them to the hospital for treatment, and were all intelligent and of good personality, but they present a fairly accurate picture of how a group of ex-prisoners with repatriation problems behaves in a neurosis hospital.

Members of the Group

(1) *Cpl. J., 30 years.* A chauffeur in civil life, happily married with one child. Had always been a stable, responsible personality who got on well in civil life and in the army. Served in the Middle East and taken prisoner in 1942. He was very roughly treated by the Italians, many of his pals died from starvation and he was too weak to do more than lie on his bed most of the day. He was sent to Germany 2 weeks before the Italian capitulation and was on a forced march for 6 weeks when he developed dysentery and coughed up blood.

On repatriation he could not stand noise, settle down or mix with people and had a horror of returning to the army, being on parades etc.

(2) *Sjt. C., 26 years.* A dispenser in civil life, with a stable, mature personality. He had some depression and headaches for a time after battle experience in 1940 but these were never sufficient to report sick. He went to N. Africa in Jan. 1943 and was taken prisoner in March. He went through very severe privations but remained well till the severe bombing of Vienna in 1945, when he became tense and jumpy and suffered from battle dreams. On return to this country he found his wife very unhappily situated, living with a difficult aunt. She became pregnant during his repatriation leave and he then found that she had congenital syphilis. He was very nervous and states that he could barely speak and was admitted to hospital for malnutrition and catarrhal jaundice for a month. While on leave he had to hold on to himself, was very depressed and frequently wished he had never come back.

(3) *Cpl. M., 30 years.* A driver in civilian life. He went to the Middle East, Nov., 1940 and was taken prisoner in June, 1942 in North Africa, after severe battle experiences and heavy bombing in Tobruk, to which he appears to have reacted well. He was restless as a prisoner owing to inactivity, but his main symptoms came on only on return to this country when he became tense and depressed with poor sleep, lack of concentration and a tendency to anxiety attacks in cinemas. He felt that the transition from prison life to home (since they were evacuated by air) was too rapid, and

did not give them sufficient time to adjust to the change. He was a previously stable man who always showed a mature and balanced, outlook, and though quiet, he took an active interest in the group and got on well with all the other members.

(4) *Cpl. B., 23 years.* He was employed as an upholsterer for 18 months before joining the army in June 1939. His home life was an unhappy one as his mother drank and quarrelled with her step-children, but he does not appear to have had any previous nervous instability. He was taken prisoner in March, 1944 at Anzio after his unit had been badly cut up and most of the others were killed when hand grenades were rolled down on to them. He was only scratched but felt too shaken to walk when taken prisoner and felt that he had "let someone down" by being captured. He was in a prison camp in Italy for 4 months with very little food. They were sent to Germany in a cattle truck and 5 men escaped. The rest were then lined up to be shot but were beaten up with rifles and bayonets instead and made to sit on their haunches all night. For a time he had recurrent dreams of this experience.

On return to this country he found his eldest step-brother, to whom he was particularly attached, had been killed in a mine-sweeper. He was irritable and depressed on admission, with poor appetite and concentration, and had great difficulty in mixing with the others.

(5) *L/Cpl. H., 25 years.* Employed as a steel-shearer until he joined the army in 1933. He served in France and the Middle East and was taken prisoner in June 1942. He had a very hard time as a prisoner and had to work down the mines in very dangerous positions. After 3 months he became nervous and depressed and lost weight. When liberated he felt no more interest in anything; "There was no more reason to keep yourself alive." On return to this country he had difficulty in settling down and mixing with others and felt unable to enjoy himself. His parents keep a public house and the father has been crippled since the last war. They tend to treat him as a child but throw a great deal of responsibility on to him and are now relying on him to run their business for them. On admission he was tense and somewhat depressed, restless and complaining of mild claustrophobia.

(6) *Pte. T., 28 years.* A painter in civilian life, he served in the Middle East and was captured in June, 1942. He was a prisoner in Italy for 18 months and then was transferred to Germany. He was in hospital for a month with his chest and has a slight chronic bronchitis. Towards the end of 1944 he became depressed and unable to sleep or concentrate. He improved at first on repatriation but relapsed on being sent to the Selection and Training Battalion.

He joined the group late and always remained somewhat timid and retiring, though he was popular with the other patients, taking a very active part in the group project, and went about with other members of the group.

(7) *Cpl. H., 26 years.* Joiner and professional footballer until he joined the army in 1939. He had a depressive illness at the age of 18, when he was

off work for several months and had thoughts of suicide. He has always been subject to mood swings with periods of elation, when his brain felt extremely clear and he was able both to enjoy himself greatly and to create enjoyment for others, followed by phases of depression. All the family are emotional and the mother has marked mood swings.

He was taken prisoner in 1940 and had a few short periods of depression. On return to this country he was exhilarated and above himself for a month and then depressed, felt something was lacking and everything was futile. He was mildly depressed but was not retarded though he had poor concentration. He was a skilled joiner and worked very conscientiously in the group, but he always remained somewhat solitary, although he took a fatherly interest in L/Cpl. H.

Formation of the Group

The group originally consisted of 6 N.C.O.'s of good personality who had all been under considerable stress. None of them had any history of previous nervous disability apart from the manic depressive, who had had a previous depressive attack. All of them exhibited symptoms of reactive type but none of them appeared to be suffering from a true neurosis.

Cpl. J. was very agitated, emaciated, restless and intolerant of noise and was separated from the rest of the group and placed in a sideroom in William Ward and given sedatives. The others remained in the Admission Ward for the first few days. They were all tense, depressed and irritable with poor sleep and appetite. One of them claimed: "I am looking for something, but I don't know what."

The first group meeting took place on Aug. 29, 1945. None of them had yet been interviewed apart from a five or ten-minute period on the previous day and all were dressed in Hospital Blues. They all appeared depressed and were tense and irritable though co-operative and eager to get well.

It was explained to them that they were now formed into a group, and would remain together and receive the same treatment during their stay in hospital. They were told that groups were formed because it has been found that they assisted patients in their recovery. This was their own group and they were free to talk about anything that they liked and to direct their meetings as they wished.

First Meeting

Cpl. J. opened at once with a somewhat aggressive request to know if it was essential for them all to wear hospital uniform, and there followed a lively discussion about feeling "marked men" and of how this revived memories of the patches they had had to wear as P.O.W.'s. (They appeared to feel even more strongly about this than the average patient.) They then spoke of the irritation which the "Out of Bounds" notices and the presence of guards patrolling the back entrances to the hospital produced. They

felt that they had only to look outside to feel at once that they were back in the *stalag* again. They asked for permission to go out whenever they wanted for a walk in the lanes and fields. They said that they would not cause any trouble and would be back at the time requested, but they felt a great need to be able to go out at their own free will. No very satisfactory answer could be given to this though they were promised that the question of wearing their khaki would be raised and they would be informed about it later.

Conversation then died down into a somewhat tense silence.

When asked what were the difficulties which had brought them here, they spoke freely of their inability to fit in on return to this country and of the difficulty in finding any topic of mutual interest. The only thing they knew anything about was P.O.W. life and of this they had no desire to speak. They described the tremendous urge to do something useful and constructive.

What appears to have precipitated the breakdown in them all was the complete frustration and uselessness of the three weeks they had spent at a Selection and Training Battalion after repatriation. They described it as a dark and clammy place, shut in by woods, so that they rarely saw the sun and where they were continually reminded of their prison camps in German forests. They were given a recruit's training from N.C.O.'s who they felt knew far less than they did about the subjects they were teaching. One lecturer told them he was only there to fill in time and an instructor said no doubt they wondered what was the point of the training they were being given and admitted that the instructors were equally in the dark.

They were all tradesmen who had jobs to return to, and they felt keenly the waste of their time and ability. Many of them were connected with the building trade and their former employers were crying out for their assistance, in view of the acute housing shortage. Cpl. J. stated that he had not only a job but a house waiting for him if he took it within 6 weeks.

While at Pipers Wood they were shown war films which had upset them all considerably. (They did not, on this occasion, enlarge on this subject. It appeared to be too painful to discuss.)

Finding a Project

The second meeting took place on Aug. 30, 1945, and Major Bridger of the Social Therapy Staff was also present. This was a short meeting to discuss a group project. The group included a joiner, several carpenters and an electrician and they discussed various schemes. They decided they would like to work for a childrens' clinic but that each of them would also like to make something to take home. They agreed to pool their abilities in these undertakings as well.

The following day they had a discussion with Major Bridger and Dr. Creak, when they were told something of the work of Child Guidance Clinics and the type of toys required. (I was unable to be present at this meeting.)

On Sept. 2 they appeared to be improving. Cpl. J. had now settled down, was sleeping better and taking his meals in the ward with an improved appetite.

They described Birmingham as a dead city; several of them went in on the previous day (Sunday) and wandered about, finding nothing of interest, so they came back. They discussed the group project they were about to undertake and had now decided that they would make a model village, including houses, a church, trees, etc., for a sand tray, and a four-roomed doll's house without a roof, for the Gt. Ormond St. Child Guidance Clinic. They appeared to have all their plans cut and dried; Cpl. H., the joiner, was to do the joinery, several of the others would do the carpentry and L/Cpl. H. (who had no special skill) was to do the painting. They were keen and confident of their ability to carry out the work. For the present they were not interested in the things they had planned to do for themselves but wanted to do something straight away for the Clinic.

Fourth Meeting

The fourth meeting was on Sept. 5, 1945. There was a marked improvement in all the members of the group. They were now all up in William Ward and Cpl. J. had improved so much that he was able to leave his small room and join the others in the dormitory and go with them to meals in the dining hall.

They were now all wearing khaki. They were informed that they would all be brought before a medical board and boarded out of the army. (They were in low point groups and it was considered better for their own recovery that they should be left in no doubt as to what was to happen to them.) They had now to recover sufficiently to take up their civilian jobs. They expressed great relief to know that they would not have to go back to the frustrating conditions they had experienced prior to their admission. Cpl. J. who would now be able to secure a house as well as a job, showed particular relief.

They began to discuss their life as P.O.W.'s and of the many methods they had employed to outwit the Germans. They described how the Americans were apt to "let go" when taken prisoner; they did not wash, slept in their boots, etc. A certain amount of feeling against Americans was expressed; they wondered why Americans behaved in this way, why American girls became "hysterical" over crooners, etc. They asked a lot of questions about Child Guidance Clinics and they considered Birmingham backward as it had only one clinic. (There was some confusion in their minds be-

tween Infant Welfare and Child Guidance Clinics.) They described what they were doing in the occupation huts, how they had already made several of the houses and of what they intended to do—making a school and shops, etc. They then said that another man who was an expert painter and who had been with one of them in a prison camp and had come with them on the same day to this hospital from Pipers Wood, had joined them in their project. They also stated two others had come with them—one of whom was already being boarded out and the other they referred to as "Blondie," but they showed no great enthusiasm that he should join in with them, but readily accepted the idea that the painter should become a member of the group.

Pte. T. was sought out and his transfer arranged so that he became a member of the group from this time onwards.

The Group Moves

Between the meeting on September 5th and the next one on September 9th, several events occurred. The group as a whole was transferred (with the rest of my patients) to Charlotte Ward, but were with a party of 13 in the bay portion of the ward, with whom they formed a small community somewhat isolated from the rest of the ward. Pte. T. had now taken on all the painting in the model village and L/Cpl. H. was deprived of his task. He became very much isolated from the rest of the group, went about by himself, came in late and was on several charges. He was admonished but was also made to give up his khaki. This he felt to be unfair since this was a greater punishment than the admonition.

At the fifth meeting on September 9th they all showed a continued improvement. They expressed approval of their new ward "because no one bothers you." They did their own cleaning and tidying, without anyone questioning their ability or inability to cope with it. All 13 were good friends but they disclaimed any interest in the rest of the ward and were still playing football for William Ward. Cpl. H. asked what would happen if they were not all ready to leave the hospital at the same time. He realized it would be upsetting for anyone to be left but were he himself that one, he would hate to feel he was keeping the others back. He was reassured that the group would not be retained for the benefit of any one individual but that in all probability they would be well enough at the same time.

A discussion took place about the Jews, and Cpl. J. expressed his feelings of dislike towards them quite forcefully, but several of the others pointed out that there were many great things which the Jews had done. They then discussed the Italians, how very primitive they were, their very poor

living conditions. Cpl. B. described Italian farmhouses where there were no lavatories and the Italians just "used any part of the surrounding country." They discussed differences between German and Italian food and stated that the German bread was very good and very sustaining. They were now able to discuss events of their P.O.W. life cheerfully and with much communal interest and friendly reference to mutual acquaintances in the different camps. Pte. T. remained shy and rarely spoke but was occasionally referred to by the others, when he joined in monosyllabically, but in spite of this he took an active interest in everything that was said.

Individual Difficulties

I called their attention to the fact that one of their members, L/Cpl. H., had lost his khaki, that this must have some effect on the feelings of the rest of the group. In tones of friendly badinage they stated that they had taken him in hand and would put chains on him, if necessary. Cpl. H. now adopted a paternal attitude towards L/Cpl. H. and had apparently taken him to work with him in constructing the doll's house. The L/Cpl. sat there, smiling somewhat self-consciously, but was obviously pleased to be taken back into the group. They went on to talk about an entertainment which had occurred one evening in the hospital and one of them banteringly turned to him and said: "Of course, you wouldn't know; you have never been in, in the evenings." They asked about the possibility of leave and were told that they could have 4 days (48 hours and 2 V.J. days) at the week-end if they would like to have it, and they all agreed they would like to go the following week-end, except Cpl. B. whose wife would not be free until the week-end after that.

Cpl. B. remained depressed and considerably worried after seeing the Medical Specialist. He was found to have a raised blood-pressure and signs of early arterio-sclerosis. The blood Wassermann came back positive but there was some doubt about the validity of this report and two subsequent reports were negative. No definite information was given Cpl. B. until the final reports could be obtained and it was difficult to allay his anxiety about his physical condition. He had been told that he must not play games or take part in any strenuous activity and he feared that he might have difficulty in getting into the Police Force on his discharge.

The sixth meeting took place on Friday, 14 Sept., when Lt. (Miss) Hussey was present. L/Cpl. H. stated that he was on a charge again for being out late and wondered if he would be permitted to go on leave that afternoon. The group then discussed the difficulties in getting in by 9.30 p.m. L/Cpl. H. had to leave and the others then discussed the fact that it was impossible for them to keep him out of trouble—that he was always coming in late and invariably came in through the Guard Room so that he was caught, instead

of in through the back ways, as the other patients did. When asked if they knew of any reason why he might be doubtful over wanting to go on leave, they stated there was no reason at all but described the details of his family life, which certainly gave room for plenty of ambivalence. (His family kept a "pub" but the father was ill and they expected a great deal of their son and placed heavy responsibilities on him.) They continued to discuss disciplinary difficulties and the problem of being in by 9.30 p.m. but appreciated that there were some who needed an additional amount of sleep. Cpl. J. described how two men on the previous night had come in late with an organized party but had taken off their boots and come in on tiptoe, which had impressed him with their thoughtfulness for others. They stated that, considering the number of P.O.W.'s we had here, they were surprised that we did not get more disciplinary problems. They were all looking forward to their week-end, Sgt. C. said he did not think they would come back, but Cpl. M. hastened to assure me that they would all return.

At the next meeting, September 21st, they had all enjoyed their leave and all returned on time. Cpl. B. was reassured about his physical condition and was due to go on leave that day. All of them showed very great improvement and were now asked to describe what they felt had gone wrong that had led to their coming into the hospital. They stated that when they were freed they still felt that they were in a rut. They had looked forward to peace so much and when it came they were disillusioned. They felt listless; though they wanted to come to England they did not know what to do when they got there. When they were released they went out and got food and were more interested in that than in their release.

Prison Experience

Their experiences in prison camps had varied somewhat. Some had remained well; others were very emaciated. Two had been on a forced march lasting 2 months but others had been on farms where the food situation had been better. On their return they felt "cheesed off" with everything—irritable and restless. They wanted to be on their own and felt self-conscious. One of them stated: "In Germany I was a stranger and you felt it was natural that people looked at you, but when I came back I felt they were looking at me more. I couldn't sit still and I couldn't go into a cafe." One of them stated: "There is a childish vanity in us all. As prisoners we felt downtrodden. When we came back we were just like anyone else but we felt we should have been given sympathy as a prisoner." Cpl. H. felt that they were given too much sympathy and that that made them worse. They felt that they were getting something on false pretences. They did not deserve it and they stressed the fact that while others had been in action, they themselves had been merely a liability to the country. They

also had some guilt over having had to work for the enemy tho' they used to do as little as possible and would even go without fires in their huts, rather than go out and get firewood which might release a woodman who could then go to the front.

They discussed how the P.O.W. had a contempt for rank. In the camps men used to put up stripes and crowns because no one over the rank of full corporal was forced to work. Among themselves they never knew who held a rank rightfully and who by "*stalag* promotion." They discussed the question of escapes and said that no one had a chance unless he could speak German. If you were caught or if you were difficult, you were sent to concentration camps. Cpl. J. commented on the fact that we heard a great deal about the conditions of Belsen and the German Concentration Camps but that the Italians had Concentration Camps which were every bit as bad and of these we heard nothing. He went on to describe the South Africans as "bad men," that they were responsible for the fall of Tobruk and had been all ready to hand over. Someone else stated that the First Division of South Africans was O.K.—they had "put up a good show."

One of the worst features of their camps had been the lack of occupation. Those who had been occupied had got on very much better. When they got back they expected to be demobilized at once and their first thought was to get on with something "useful."

The group continued to improve and became gradually more and more dispersed among the rest of the ward and hospital: though they remained very friendly, they showed ever-widening interests and appeared no longer to need the security of a small group. Cpl. M., Cpl. J., Sgt. C. and Pte. T. remained more or less together and Cpl. H. and L/Cpl. H. occasionally joined forces, but Cpl. B. remained very much on his own. Cpl B. had considerable guilt and felt that he ought to have been killed rather than taken prisoner. They finished their group project, the model village and doll's house for the Gt. Ormond St. Clinic, and most of them undertook some project, such as a toy or handbag, to take home.

A marked change occurred in L/Cpl. H. after he was elected a ward representative during a ward meeting. He was no longer out late and there was no further disciplinary difficulty and he became a very conscientious and responsible ward representative. He now appeared to have found a niche in the social system, where he was a valuable member of the community and no longer just accepted in the group by the kindly toleration of his more skilled colleagues.

On Oct. 2nd they all appeared before a medical board and were placed in Category "E". Cpl. H. still showed some tension and slight depression but the others had settled down well and showed no overt anxiety. Cpl. J., in particular, showed an enormous improvement—his face had filled out and he had lost his irritability and much of his intolerant attitude.

Post-Prison Experiences

Their last meeting was on Friday, October 5th, when Major Foulkes was also present. The first part of the meeting was taken up in collecting the facts about their stay at the Selection and Training Battallion after they were returned to this country. They had all of them broken down there and an official complaint about their treatment was to be sent up to the War Office. They described how they were shown Japanese atrocity films with close-ups of civilian women being shot and living prisoners being used for bayonet practice. Also the bombing of a Chinese city, with the people running in all directions, trying to get away. They were forced to see these films but most of them shut their eyes and all of them were very upset when the film ended. Cpl. J. said: "I suppose it was intended as propaganda, to make us want to fight the Japs, but I'd have run miles if I'd seen a Jap, after those films."

Their feelings of frustration in the camp were very great and they wanted to know why they could not have done something "useful." They felt it was a waste of money, giving them all new equipment which they would never use (they were all low Release Groups) and stated that some of the instructors knew considerably less than they did and that their knowledge was merely from books and not from experience. A sergeant, giving them gas instruction, said to them: "You'll want to know why you're doing this. So do I," but one of them added: "One of the best lectures we had there was on gas." The officer who gave it made it very interesting." An Indian and Austrian also gave them good lectures and the lecture on civil rehabilitation units was good but they had little patience with the officer who started his lecture by saying: "I've just come here today to fill in time." They also complained that they had to do a 5 mile run up hill, many of them before they had been medically examined.

They felt that many others should have to come to this hospital with them, but the Medical Officers were too busy and many men would not report sick. They felt as if they were treated like children at the camp and were allowed no say in anything. This was made more difficult because in their prison camps they had enjoyed considerable democratic freedom. They had their own committee of representatives and a private had as many rights as a Warrant Officer. Anyone who failed to come up to the required standard could be voted out. They had made their own rules and had seen that they were carried out for the good of the community. They discussed how in prison camps you had to develop thought and initiative, otherwise you starved. This kept them all mentally alert while they were constantly planning how to get the better of the Germans in order to get food, etc. Those who remained inert, lay on their beds, got a minimal amount of food and many of them were later removed to the Mental Hospital.

When they returned to duty in this country at the Selection and Training Battalion they were no longer allowed to think for themselves. This led to a discussion of some of the difficulties in this hospital and how they would like to alter things. Major Foulkes asked them what changes they would make. They were at first diffident in answering this but when they realized his question was serious, they attempted to do so. Cpl. J. suggested that we should get rid of the A.T.S. but the others did not agree with him. He adopted a somewhat rigid moral attitude that because of their proximity they placed temptation in the way of the men, but the others reminded him that he was a staid married man but this did not apply equally to all the other patients.

Cpl. J. then suggested that they should be allowed out until 10.30 p.m. so that they could feel they were men and not children, but that this was late enough for anyone and that it should be enforced very strictly and punishment for those who broke this rule should be made more severe. They described how in this hospital they considered that there were two factions—the psychiatric and the administrative. They felt that the psychiatrists had moved with the times but that the administrative side had not done so. Since we were now for all practical purposes a civil rehabilitation unit, some modification of the previous military hospital was required. They felt it should be run something like a rest camp and described a rest camp they had known in the Middle East where they stayed for 10 days, in which all ranks were abolished and everyone did his own fatigues. Anyone who saluted was threatened with immediate return to duty; the Officer–In-Charge and his second in command were called by their first names and a friendly democratic atmosphere prevailed. When they left the camp to return to duty they had no difficulty in recapturing a more military atmosphere. They stated: "When we left there the R.S.M. became an R.S.M. again but he was not one while he was there."

Commentary

These ex-prisoners-of-war were admitted together and readily formed a cohesive group. At first this was a well-defined entity which kept itself separated from the rest of the ward and the hospital and showed marked antagonism to other races and creeds in their conversation. As they improved, their social adjustment extended to an ever-widening field and the group gradually dispersed as they no longer needed the protection and support of the small group community.

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WINTER GENERAL HOSPITAL

Winter General Hospital, Topeka, Kansas, was established as an Army Hospital on December 14, 1942. On January 11, 1946, it was formally taken over by the Veterans Administration. At the ceremonies held on this occasion, the new manager, Dr. Karl Menninger, accepted the hospital for the Veterans Administration with the following words:

It is not for me to accept this hospital—it is the property of the people of America. I can only accept the responsibility of helping to make it the best hospital in America. I can do that only if I have the cooperation not only of a willing and loyal staff and fellow employees—which I do have—but the sympathetic and helpful backing of the people of Topeka and the citizens of Kansas. For this I ask, and I have every assurance that I shall get it. From Washington we have received every possible support. General Bradley called last night to tell us again what we already know: that he is interested, that all of our personnel in Washington are interested and desirous of seeing us make this a great hospital. At the same time many people of Topeka called us; many of you have been so kind as to brave the weather and come out today to encourage us, so that we have no fears.

Abraham Lincoln said many years ago something which seems very appropriate to me in the matter of dedication: "It is not for us to dedicate (this hospital); it is for us, rather, to be dedicated here to the unfinished work that they"—and you know who they are—"have thus far so nobly carried on. It is rather for us to be here dedicated to the great task remaining before us; that from these honored ones we take increased devotion to that cause for which"—some of them—"gave the last full measure of devotion; that we here highly resolve that these dead shall not have died in vain."

Now I want to move forward in history eighty years and quote a contemporary:

"The shooting has stopped. Our enemies have been defeated. The battle news is gone from the newspapers and radio. And so there is a natural inclination, on the part of the home folks, to say: 'The war is over—let's forget about it.'

"I say the war is not over. It will not be over until the men who fought it, now coming home at the rate of a million a month, are given the op-

portunity to find employment, rebuild their lives, and resume their responsibilities as civilians.

"Not long ago we pinned our faith on these men in battle. They now pin their faith on us for a chance to make good in this world to which they have returned. Until the people at home fulfill this faith, finish this task, our victory will be clouded and incomplete.

". . . The veteran who has experienced the war cannot forget it, even if he wants to. But the man at home who has merely read about the war tends to forget it rather easily; only by a deliberate and difficult act of the imagination can he keep in mind a picture of what the fighting men went through. That is why the banners of welcome fade so quickly.

"Less than 6 months after V-J day, we are already beginning to run into that kind of forgetfulness. One man describing the situation in his town put it this way: 'With the first 10 men who came back it was, "Hail the conquering heroes." With the next 50 it was, "Glad to see you back, fellows." With the next 200 it is, "Gee, this mob of vets is getting to be quite a troublesome problem."'

"Yes, that is human nature, but it is a weak side of human nature. It shows a lack of imagination amounting to cruelty. These men who are coming back now are, on the average, just like those who came back to the first glowing gratitude of victory. Each of these, like those others, has dreamed for months and years of this return. In foxhole, ship, or plane, in boredom, homesickness, or terror, he has cherished the warm thought of his home town, with its familiar streets, its helpful friends, and a worthwhile civilian job.

"We must never forget this; we must ceaselessly remind ourselves of it.

"Any short-memoried community, with citizens too busily engaged in their own peacetime planning to give adequate care, counsel, and guidance to their returning veterans, is not only making trouble for itself in the future, but is neglecting its own priceless assets."

These are the words of our Chief, General Omar Bradley.

And these are the words of our medical chief, Surgeon General Paul Hawley:

". . . I am committed to only one principle, that the veteran shall receive the best in American medicine. I can't support any program which denies him the best in American medicine, and I am quite sure it will be a long time before we find that, in any quantity at least, in other than the civil practice of medicine.

"If I am not permitted to bring the best in American medicine to the veteran, I shall withdraw at once from the program. I shall neither let down the veteran nor betray our own great profession."

Winter General Hospital is to be a general hospital. This means that we shall accept as patients, veterans suffering from all kinds of illnesses. But

we shall remember in this hospital what Plato said many centuries ago: " . . . so neither ought you to attempt to cure the body without the soul; and this is the reason why the cure of many diseases is unknown to the physicians of Hellas, because they are ignorant of the whole, which ought to be studied also; for the part can never be well unless the whole is well. . . For this is the great error of our day in the treatment of the human body, that physicians separate the soul from the body."

You will have to trust me and my staff to find the best technical means for accomplishing the ends that you, President Truman, General Bradley, Doctor Hawley—and Plato—want us to accomplish. Some of these you might not, without some study, precisely understand, but the spirit of this hospital you must understand and you must help us with. The spirit of this hospital I can best express by a quotation—not from a doctor, not from a philosopher, not from a General, but from a writer whose name is John Cowper Powys.* He was not discussing hospitals, or veterans, or citizens of Kansas; he was discussing culture. But what he said is something which I have read to some of you several times. I read it to my doctors quite often, and I read it to myself over and over. Now I want to read it again, to you:

"There is nothing more expressive of a barbarous and stupid lack of culture than the half-unconscious attitude so many of us slip into, of taking for granted, when we see weak, neurotic, helpless, drifting, unhappy people, that it is by reason of some special merit in us or by reason of some especial favour towards us that the gods have given us an advantage over such persons. The more deeply sophisticated our culture is the more fully are we aware that these lamentable differences in good and bad fortune spring entirely from luck.

"It is luck: luck in our heredity, luck in our environment, (luck above all in our bringing up,) that makes the difference; and moreover at any moment fortune's erratic wheel may turn completely round and we ourselves may be hit by some totally unforeseen catastrophe. It is luck, too, springing from some fortunate encounter, some incredible love-affair, some fragment of oracular wisdom in word or writing that has come our way, that launched us on the secret road of health and on the stubborn resolution to be happy under all upshots and issues, which has been so vast a resource to us in fortifying our embattled spirit. At any moment we are liable, the toughest and strongest among us, to be sent howling to a suicidal collapse. It is all a matter of luck; and the more culture we have, the more deeply do we resolve that in our relations with all the human failures and abject and ne'er-do-wells of our world, we shall feel nothing but plain, simple, humble reverence before the mystery of misfortune."

This is the spirit in which we intend to conduct this hospital.

* Powys, John Cowper: *The Meaning of Culture*. New York, W. W. Norton & Co., 1929, p. 186. By permission.

SOME RECENT OBSERVATIONS ON THE USE OF HYPNOSIS IN PSYCHOTHERAPY*†

By MARGARET BRENMAN, Ph.D., and MERTON M. GILL, M.D.

Although we do not yet know whether hypnosis is actually an altered state of consciousness or whether it is a highly charged emotional relationship between two people, or both, we do know that significant changes take place in the dynamic play of psychological forces in a hypnotized person. We know moreover that these changes may be utilized by the psychotherapist in a variety of ways which we will describe briefly. Adherents of various schools of psychiatric thought will naturally apply hypnosis in a way which is consistent with their own set of systematic principles. Our work is based on psychoanalytic principles.

We shall discuss briefly the question of hypnotizability, methods of inducing hypnosis, and the relationship between the degree of hypnotizability and therapeutic success. The remainder of our presentation will be devoted to a description of some of the ways hypnosis can be used as a tool of psychotherapy—and to a discussion of the hazards one may encounter.

First, on the question of who can be hypnotized: there is fairly general agreement that between 78 and 97 per cent of the total population can be hypnotized *to some degree*, but that only about 20 per cent can be deeply hypnotized. Erickson's work makes it appear, however, that perhaps this estimate of deep hypnosis in one out of five persons is unduly pessimistic. Although he agrees with other investigators that neurotics are on the whole more difficult to hypnotize than normal persons, his figures for deep hypnosis in both groups far exceed the 20 per cent estimate.

We have thus far been unable to conclude either from the literature or from our own experiences that patients belonging to any particular nosological category are most easily hypnotized. Contrary to the generally-held belief that most hysterics are particularly susceptible to hypnosis, it has been our experience so far that this group is not distinguished by ease of hypnotizability. Undoubtedly, *hypnotizable* hysterics are the most responsive to therapy, but it is well-known that hysteria has a relatively good prognosis with any form of systematic psychotherapy. Currently, one of our best subjects is a schizophrenic girl, despite the fact that most authorities agree that schizophrenics cannot be hypnotized. In short, we are

* A condensed version of a paper read at the May, 1945, meeting of the American Society for Research in Psychosomatic Problems. It was presented in abstract in the January-February issue of *Psychosomatic Medicine*.

† This report issues from a research undertaken on a grant from the Josiah Macy, Jr. Foundation.

led to the conclusion that we cannot predict hypnotizability and that the only way we can test a patient's susceptibility is by trying to hypnotize him.

Inducing Hypnosis

Regarding the second practical problem of the most effective way of inducing hypnosis: we have found that the time-honored standard method of monotonously repeating to the patient that he is relaxing and going to sleep will succeed only with the easily hypnotizable. Such routinized procedures neglect the fact that in the induction of hypnosis a complex psychological interplay between two people is going on, and the therapist must be eternally alert and ready to capitalize on the slightest signs. The nuances of procedure to be introduced to fit the immediate needs of a particular patient have been very incompletely verbalized in the literature, but we do want to stress the fact that an entirely flexible approach which departs from the rigid formulae often employed promises to increase the percentage of patients who can be hypnotized.

It has been frequently observed by workers in the field that there seems to be no reliable correlation between the depth of hypnosis obtainable in a patient and the therapeutic result. At first glance, this is extremely puzzling inasmuch as the natural supposition would be that the deeper the hypnosis the better the chances of cure. In line with a suggestion made some years ago by Schilder[2] some of our recent experiences have shown us that another factor, which seems as important as the depth of hypnosis judged by standard criteria, plays a significant role in determining the therapeutic response. This second factor may be thought of roughly as the extent to which the patient permits himself deep emotional participation (whether consciously or unconsciously) in his hypnotic experiences. Thus, a patient who is in a "light hypnosis" may become far more deeply involved in the procedure than one who is in a deep hypnosis.

For example, we worked with a 54-year-old depressed woman and found her to be an excellent subject in that all the usual hypnotic responses were to be elicited from her with very little difficulty. If told while in hypnosis to hallucinate, she promptly did so; if pricked deeply with a sterilized hatpin after complete analgesia had been suggested, she bled without any evidence of an experience of pain. At first, encouraged by her extreme responsiveness, we attempted to treat her depression and insomnia symptomatically by direct suggestion, but her symptoms remained unchanged. When another therapeutic effort was made, this time by way of an attempt to explore the background of her illness, we were again met by the same impenetrable barriers. She would produce richly detailed childhood memories when instructed to do so, but with complete detachment. It

was possible, thus, to produce a very deep hypnosis in this patient according to the usual criteria but she actually remained aloof from the entire experience.

Case Report

In striking contrast to this case stands the account of a 28-year-old soldier, discharged from the army in a state of depression and anxiety, both of which were sufficiently intense to make hospitalization necessary. When we were studying his hypnotizability, we felt at first that he was a poor subject because his responses to even the mildest of suggestions in hypnosis were uniformly feeble. When we were on the point of concluding that, according to our standard criteria, he was a poor subject for hypnotherapy, events took a surprising turn. He came in one morning intent on telling a dream he had had the night before. After listening to his account of the dream given in the normal state, the therapist gave him the usual signal to go into hypnosis but did not attempt now to test the depth of hypnosis. The patient was simply told to re-live the dream and to carry on now where it had been interrupted the night before.

In the dream he walked up a mountain path which led to a cave. He had wanted to see what was in the cave but the dream had ended. Now, in hypnosis, he was able to continue with the dream. He described a figure (which he alternately felt was "a witch" and "my mother") as though he were watching a movie, talking in the present tense. Gradually his breathing became labored and his face contorted; it was evident that he was experiencing intense feeling. He began to plead now with the dream-figure, imploring her, "Tell me something—anything—is that you, Mom?—Tell me whether it's you. Just say yes or no or something. When did I ever start being afraid?" As he went on, his voice rose and in marked contrast to his usual diffidence, he clenched his fists and began to accuse his mother, who had actually always dominated him, of having done something to him long ago to scare him; he shouted that he wasn't afraid of anything now and that he could "lick the world . . . let the chips fall where they may." Directly following this session, the patient significantly improved.

During the remainder of his stay in the hospital he was seen in waking psychotherapeutic interviews about ten times. After he had gone back to work, he came in for a few follow-up sessions and on one occasion he was asked once more to re-live his dream in hypnosis. His response was startling. This time he identified the woman in the cave as unquestionably his mother and climbed on her lap, seeing himself in a velvet suit and feeling young and small; then he climbed off and tried to walk away, feeling like a "grown man". He oscillated between these two roles for a while and finally decided that at last "the spell was broken" and he could leave

the cave and his mother forever and assume his adult responsibilities. He reports that after six months he has never felt so independent and completely at ease in his life.

In this instance, the hypnotic relationship seemed to serve as a springboard for the release of an apparently central conflict in spite of the fact that this man would have been classified as a poor subject according to standard criteria. This case stands in sharp contrast to the preceding one where all of the classical signs of a "deep hypnosis" were present but where significant emotional involvement was absent. It is probable that therapeutic success hinges far more on the degree of such emotional participation than on the depth of hypnosis *per se*. Although we have many speculations regarding the "mechanism of cure" in such cases, we will reserve these for a more extended discussion.

Recent Uses

Although time limitations make it impossible to describe the many ways in which hypnosis may be used as an auxiliary tool of psychotherapy, we should like to make it clear that the classical technique of using hypnosis as a medium for commanding the disappearance of symptoms is now rarely employed. Some of the more recent uses are as follows: A therapist may use hypnosis simply to establish initial rapport with a previously inaccessible patient or he may employ it to alleviate acute symptoms (e.g. mutism) which preclude "expressive psychotherapy".

In a case of *anorexia nervosa* in an adolescent girl, who had remained inaccessible and combative for many months, hypnosis was recommended as a last resort. Although her hypnotic responses were not in themselves spectacular it now became possible to establish a fruitful therapeutic contact with her, with psychotherapy being then carried on in the waking state. In another instance, we treated a girl who, in an acute attack of *astasia-abasia*, was at the same time unable to speak intelligibly. By direct suggestion in hypnosis she was sufficiently relieved of the symptoms to enable her to walk and to talk and then entered a period of extended psychotherapy. Another therapeutic use of hypnosis was seen in the case of the soldier whom we described. For him hypnosis made possible, in a way which we understand only incompletely, a sudden focussing on and resolution of a major emotional conflict. We realize that such "overwhelming experiences" do not change the basic character structure of the patient, but we have seen the establishment of new well-integrated adjustments.

We have been investigating also the possibility of accelerating psychoanalytic treatment by using hypnosis. Although we cannot yet make any generalizations regarding the kind of illness in which this is feasible, we should like to call attention to the case report included in this issue of the *Bulletin*.

Obstacles

Regarding the dangers of hypnotherapy we must say first that they have usually been much exaggerated. For example, the belief that hypnotherapy results in over-dependence on the therapist is no more true here than in any other form of psychotherapy nor is it true that patients become "addicted" to hypnosis and rely on it as one would on a drug. On the whole investigations of supposed "injuries due to hypnosis" have revealed far more smoke than fire. However, we feel it is important to state certain cautions which issue from our experiences. We have found, for example, that a patient may utilize being in hypnosis as an emotional indulgence and unconsciously block the therapy. We met this difficulty in treating a man with a severe character problem. He was an excellent subject whose productions were profuse and highly symbolic with pictorial imagery constituting a large part of his verbalization. The attempt to reach a translation of the symbols led only to the production of equally symbolic equivalents. The patient seemed to lose all emotional restraint and fell into a pattern of child-like sobbing outbursts which continued for treatment hour after treatment hour. We found it impossible to break through this defense. The hypnosis was to him an opportunity to pour forth a psychic stream with utter abandon. He appeared to believe that by hypnotizing him the therapist had taken upon herself the responsibility for organizing and understanding the data. Although the patient accepted this interpretation intellectually, the same pattern continued as long as the hypnosis continued. There were periods in which it seemed broken but again it would return. The hypnosis was terminated and non-hypnotic psychotherapy was instituted. It may be that as we learn more about hypnosis we will learn how to overcome such an obstacle but it must clearly be seen that hypnosis itself can become the technique of resistance.

A contra-indication to hypnosis which is universally given—and justly so—is the presence of strong paranoid ideas. It is clearly risky to lend reality support to the delusion of being under the influence of another person, a belief so common in paranoid conditions. We have had one experience in this connection with a patient whose latent paranoid trends we did not at first see despite careful clinical studies and psychological tests.

Case Report

He was a man in his forties who came to the clinic complaining of feelings of inadequacy and difficulty in applying himself to his work. The story he told us of the peculiarly strong influence on him of a chiropractor who had treated both himself and his wife by most unorthodox methods put us on our guard, but we proceeded with hypnotic therapy. The patient was easily hypnotizable and began to produce material readily. He was seen

in interviews by two male therapists together—our practice having been at this time to have an observer present in some cases. The seating was such that he was between the two therapists. He began to grow anxious, and reported an experience in which he thought he had seen a man peering at him one night through a window. He could not be sure whether it was a dream or had taken place while he was awake. Then he had a dream in which two men were holding him on a toilet, one on each side. He was not sure what their intentions might be and did not himself associate them with the therapists. Careful questioning elicited the fact that he was not at all certain that the influence of the hypnotist terminated at the end of the interview. The dream itself was untouched and the hypnosis was abandoned. After a period of psychotherapy the patient was discharged apparently none the worse for his experience. It was clear that the hypnosis had stimulated his latent paranoid trends in an explosive way that might have led to a psychotic outbreak.

Conclusion

It is worth emphasizing that in psychiatry as in other branches of medicine a powerful tool can sometimes be a dangerous tool. Hypnosis forges a link with unconscious primitive material and, especially in therapy which aims to uncover conflicts, should be used with the caution it deserves. For this reason we feel that hypnotherapy should be regarded as one of the specialized tools of the trained psychotherapist, who will appy it within the solid framework of his theoretical understanding and his clinical experience.

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TECHNIQUES OF HYPNOANALYSIS ILLUSTRATED IN A CASE REPORT*

By MERTON GILL, M.D., and KARL MENNINGER, M.D.

This paper issues from the research on the combined use of hypnotic and psychoanalytic techniques being conducted at the Menninger Clinic. It will describe the hypnoanalytic treatment of a patient presenting a varied symptomatology, including neurasthenic, hysterical and depressive features. Our major emphasis will be on material illustrative of the technique, although we shall also discuss some more general aspects.

The Case History

The patient was a 36-year-old housewife, married to a moderately successful professional man living in a small southern town. When asked to give her chief complaint she stated, "I didn't come here because I thought I needed to; I came because the doctor said I was psychoneurotic and my husband agreed with him and asked me to come. If he had told me I had to come, I wouldn't have come, but I came only to please him."

In spite of this, the patient gave a long story of somatic complaints and illnesses extending back over many years. When given an opportunity, she launched into a description of these, beginning with a cold at the age of two weeks and a boil at the age of one month and ending with the present complaints of headaches, diarrhea, cardiac palpitation, excessive sweating, depression and "nervousness" and frequent disturbing dreams. The patient had had several repairs of the cervix uteri, two Caesarian sections, an appendectomy, and an ovarian operation. In 1941 she had been hospitalized for a year at a tuberculosis sanitarium with a diagnosis of bronchiectasis. When informed by us that the physical examination revealed no significant organic disease, she was resentful and expressed the view that our studies had been incomplete.

Despite these and other evidences of antagonism and resistance, such as her refusal at first to complete the psychological tests because they took longer than she had anticipated, the patient responded rather quickly to a sympathetic attitude, completed the diagnostic study and accepted the treatment recommendations.

According to the history given by her, she had been reared in a small New England community. Her father, though a man of very modest means, held a respected position in the community and was a pillar of the church. He was always "nervous" and easily upset. He died several days after a fall at the age of 67, having been nursed in this last illness by the

* Part of a research undertaken on a grant from the Josiah Macy, Jr. Foundation.

patient. The patient's mother, described as warm and devoted to her children, was living and well at the age of 65. The patient was the fourth of eight siblings of whom only four are still living. The only one who figured prominently in the treatment was a three-year-younger brother. The history seemed to indicate clearly a turning point in the patient's life at about the age of 13. She was severely ill then with typhoid fever and an older sister who contracted it at the same time died of it. During convalescence from this fever the patient developed many presumably functional disturbances including tremors, smothering spells and episodes of anorexia. The doctor advised her "to live as though she had tuberculosis" and as a result the patient's high school career was marked by an avoidance of the usual extracurricular and social activities with strong emphasis on doing well in her studies. She was thus set off from her school-mates as separate and "queer". She taught school from 17 to 19, then had two years of college followed by a year of work after which she married. She had three pregnancies, two, six and eight years respectively after marriage. All of these were turbulent. The first baby, a boy, lived only two hours and his death was ascribed to a birth injury during the difficult labor. The last two were also boys, both delivered by Caesarian section, the first of them living and well at the age of eight but the second dead (at birth) of some congenital defect of the lungs.

Three months after the birth (and death) of this child, the patient suffered a "nervous collapse" ascribed to her depleted physical condition, grief over the loss of her child, and the "unreasonable" demands of a woman's club to which she belonged. This collapse was characterized by insomnia, marked increase of tremor in her hands, irritability and restlessness, together with a special fear of sharp instruments, with the feeling that if she were not prevented from doing so she would seize a knife or scissors and plunge it into her heart. The many physical difficulties described at the time the patient presented herself at the Clinic were present at this time also and continued then for the next six years—i.e., up to the time of her admission to the Clinic—in spite of much medical therapy.

The psychiatric examination revealed a small, neatly dressed woman who, despite her expressions of resentment against doctors, her protestation that she was being unjustly stigmatized as psychoneurotic, and her sometimes tedious insistence on detailing her multiple somatic complaints, gave the impression of being a basically friendly and warm person. She showed marked anxiety, many nervous mannerisms, and a marked fluctuation of mood, though with a keynote of depression. Her thought processes were intact. A diagnosis of psychoneurosis with neurasthenic, hysterical and depressive features was made, with the probability that at least some of the somatic complaints were conversion phenomena. These findings were

confirmed by the psychological tests which pointed in addition to much inhibition about sexual matters and to the possible presence of some obsessive ideation.

Hypnotizability Study

During the preliminary examinations the patient was studied for hypnotizability. At first the indications were rather disappointing, only a slight hypnosis being obtainable. An attempt was then made to deepen the hypnosis with intravenous sodium pentothal; the technique used was to inject the pentothal and carry out the same hypnotizability test with the suggestion that the effect achieved by the drug could be produced without it, thereafter. Under the pentothal hypnotizability was slightly improved but (in the next test) without pentothal, it was much improved with partial immediate and posthypnotic amnesia and the patient was accepted for hypnoanalysis.* A formal re-test of hypnotizability was not carried out until the treatment was well advanced and then it was found that the patient was capable of deep hypnosis with complete amnesia and, as will be later described, a regression to an earlier age could also be accomplished.

General Description of the Treatment Technique

The patient was seen in 50-minute interviews, five times a week for a total of 133 interviews. Almost without exception these were conducted with the patient in the hypnotic state. She would come in, lie down, listen to the therapist's count to 10, lapse into deep hypnosis, and begin talking. The therapist sat in view of the patient, not behind her, but throughout the interview her eyes would be closed, since a sleeping type of hypnosis was induced from the beginning with the suggestion that the patient would be unable to open her eyes. Hypnosis was terminated by saying the letters from A to G and marked by the opening of her eyes. She would then arise and leave promptly except upon a few occasions when she was slightly dizzy after a hypnotic regression. The patient spontaneously reported dreams almost from the start, and for the first 10 hours an attempt was made to deal actively with these with the hope of reaching interpretations at once. When it became clear that this was doing little other than to stimulate the patient's resistance, the technique of free association was explained and thereafter it was understood that the patient was to associate freely unless the therapist actively intervened with an interpretation or some special instruction. This and other experiences have convinced us that this is the most fruitful and practical technique to use in the beginning of a hypnoanalytic treatment. Even later on, the technique of free association unless

* Numerous attempts to repeat this improvement of hypnotizability through the use of pentothal with other patients have been uniformly unsuccessful.

the therapist otherwise intervenes, seems to be the best. At no time was amnesia suggested nor did it spontaneously develop; the patient always remembered the material of the hypnotic interviews.

The Material of the Interviews

Before describing some of the special hypnotic techniques employed, we will give a brief survey of the material which appeared during the course of the treatment. There was nothing unusual about this material in content. It was almost certainly no different from that which would have been elicited had this patient undergone a psychoanalysis. The feature which differentiates it is the relative rapidity with which it came, and the absence of long periods of resistance and digression. We do not believe that in a psychoanalysis of equivalent length this amount of "deep" material would have been obtained.

Summarizing this material will of course make it seem much more "pat" and logically consecutive than was actually the case. The treatment material falls into several distinct periods. The first period occupied 60 hours. After an initial period of orientation in which the patient expressed some lack of confidence in the therapist because she was not sure of his religious principles, the first really important material was the confession of a platonic love affair in college. In fantasy there still persisted strong feeling for the man, though she now had almost no contact with him. After this confession there appeared a progressive concentration on her wish for father and therapist, culminating in a dream in which the patient seemingly was 13 years old, and was rejected by her father. This was correlated with the recollection that at the age of 13 she had pressed herself against her father in an embrace, had felt his penis against her body and had become sexually aroused, was pushed back by him and sternly told never to do that again. It was this episode which had accounted for the turning point in the patient's life at the age of 13 which had seemed so clear in the history. Following this memory, all the patient's symptoms dramatically disappeared and she wanted to conclude the treatment and go home. She was told she was making excellent progress but that if her recovery was to be lasting more work would have to be done. She reluctantly agreed to stay and almost at once many of the symptoms returned.

The next 40 hours (61st to 100th) were concerned with progressively clearer expressions of feelings of inferiority, at first related to her small stature, her feeling of educational and intellectual inadequacy, then more clearly her repudiation of femininity and envy of masculinity, until finally she clearly recognized her penis envy. After this she said that "an internal pressure which I have felt for years has suddenly been released."

The third period (the 101st to 119th hours) dealt with her feeling that

she had been cheated by God who had made her a girl, and with her long time hope that a penis would grow. In hypnotic regression it was found that she believed menstruation was caused by the monthly tearing of a small piece of flesh which might otherwise have grown into a penis. It also became clear that she hoped to get a penis from the therapist and was resentful and disappointed by his failure to give her one. This was followed by recognition of her unconscious wish to get the envied penis by forcibly taking it away from a man. In the 118th hour she reported a dream in which a man did something to her from behind and left his penis in her. In the dream she thought to herself, "This is what I wanted", but then changed her mind, took out the penis and threw it away.

In the last 14 hours (120th to 133rd) there was gradually diminishing evidence of resentment that she could not have a sexual relationship with the therapist and also get a penis from him, terminating in a dream of a house (obviously her own body) which she had seen before in a run-down and inferior condition but which now seemed quite acceptable; she also dreamed that the therapist gave her a token of affection by kissing her and then saying goodbye. She seemed under a fair degree of pressure to return home, and left a few days earlier than she had at first planned so that she could attend a special church meeting.

At the close of the treatment the patient was free from all her symptoms with the exception of a slight tremor when in particularly disturbing situations. The mechanisms producing the somatic symptoms were only partially clear. The diarrhea ceased when the patient began to speak really freely, with the confession of the affair in college. Headache regularly reappeared when an attempt was made to force the emergence of disturbing material. The excessive sweating gradually disappeared but its mechanism was not elucidated beyond its familiar association with conscious anxiety. The fatigue disappeared as the problem of weakness and inferiority related to femininity was worked through. The only suggestions about the dynamics of the tremor were that it seemed to her perhaps the trembling of a weak feminine creature and it was perhaps related to a tremor which her father had had for many years and which the patient regarded as like her own.

In a follow-up letter several months after leaving treatment the patient reported that her breasts had been a little sore for several weeks and that first she and then her husband independently had noticed that they increased a little in size. The patient recalled that during adolescence she had tightly bound her breasts in the attempt to hide their development. During the treatment she had at times expressed the feeling that her breasts were not large enough. She herself interpreted this belated growth as resulting from the fuller acceptance of her femininity which the treatment had made possible.

Psychological tests were repeated during the patient's last week in treatment. The comparative report states that the previously existing depressive trends were no longer present. This was shown by the rise of the I.Q. from 108 to 126, the increase of the Rorschach responses from 14 to 21, and greater speed in the word-association test. The report further noted "greater freedom for the expression and experiencing of affect and anxiety. Association disturbances to words of sexual connotation were much less marked than in the first test."

A recent follow-up report two years after discharge stated that the patient is free of symptoms and leads a busy and happy life. A striking feature of the follow-up letters from the patient is the continued work she has attempted by way of analysis of dreams and other material. One of these dreams will be reported later. This independent self-analysis certainly presents a much different picture from that which is ordinarily given of the hypnotic subject as a passive automaton capable of no initiative or independent thought and bound forever to the hypnotist by an unverbalized and unresolved affective tie.

Transference Material

Much of the transference material has already been indicated by implication in the statement of the psychodynamics. After the short initial period of irritability which has been described, the patient quickly developed an exaggerated deference to and regard for the therapist. She often called him "sir" and once even inadvertently substituted his name for God in her prayers. Though this attitude was pointed out upon a number of occasions, it was never radically changed. It was still her attitude when the treatment closed. There were a few short-lived outbursts of resentment in response to such things as the suggestion that the treatment continue after disappearance of symptoms at the close of the first 60 hours, and the examiner's refusal to give her advice about some practical matters such as whether she should room with another patient. On occasions when her wish to have sexual contact with the therapist or to obtain a penis from him appeared most clearly, she would sometimes react to interpretations with the feeling that the therapist was laughing at her for presuming to think of herself on intimate terms with him. A topic which was for some time almost taboo in the treatment was the subject of religion. The patient believed that the therapist "scoffed" at her religious principles and regarded her belief in the efficacy of prayer as naive foolishness. No attempt was made to analyze the patient's religious attitude except in superficialities. She herself, however, recognized the connection between her ideas about her father and about God and explained that an adolescent period of refusal to attend church was due to anger that God had made her a woman.

In the 36th hour the patient confessed for the first time to masochistic fantasies she had had for many years in which men cruelly mistreated prostitutes, especially by techniques of stretching the vagina. This proved to be related to an experience at the age of four when she had seen her father's penis, considering it very large, and to memories of her mother talking of intercourse as an unhappy duty. Further material seemed to indicate that these masochistic fantasies were related to the hypnosis, too. For example, the patient felt during the first phase of the treatment that in hypnosis she was "in the power" of the hypnotist. She was much disturbed by reading in the newspaper of a woman who was charged with enslaving two other women through the use of hypnosis and while discussing this was seized by a mixture of fear and sexual excitement. On one occasion when the therapist said, "We'll try something new today," the patient instantly felt a spasm in her vagina. The elucidation of the relationship between these masochistic fantasies and the patient's reaction to the hypnosis did not affect her hypnotizability at all. It must be stated, however, that the topic was not extensively treated. The patient was as deeply hypnotizable at the end of the treatment as at the beginning. On the last day that she was seen she was for the first time hypnotized with her eyes open.

Six months after the termination of treatment the patient sent in an extraordinary letter in which, among other things, she stated that she realized that during treatment her original neurosis had been replaced by a "substitute neurosis," that her neurotic attachment to the therapist had not been fully resolved during the treatment but that now, beginning by way of a dream which she had herself analyzed, the problem was solved. Her method of procedure with this and other dreams was to lie down as she had in hypnosis, close her eyes and allow herself to freely associate and work on the dream elements "just as I used to do with you." This procedure undoubtedly involves some form of autohypnosis. The patient dreamed:

"My husband and I were staying at a place which was not our home. We seemed to have two rooms which had a connecting door. The second of the two rooms was quite small and it was my private room. My husband did not enter this room though he sat in the other room and looked into the smaller room and watched me. The light in this private room of mine would not burn but enough light came in from the other room so that I could see enough to comb my hair. I tried to make the light burn but I could not. I asked my husband to help me make it burn but he only answered that he could not make it burn for me and I felt in the dream he was not interested. Then I went to a big room which was like a gymnasium. The lights were not on there either but I thought, 'I cannot make the light in my room burn but I can make all these lights burn.' I went to the fuse box, put in a new fuse, and one by one the lights began to come on until they were all burning. I wondered why I could not make the one light burn."

The patient interpreted the dream as follows:

"The one light in a room which only I enter represents you. I think that because I was having the struggle with my emotions concerning you at the time I dreamed this dream. The little room which only I entered represents my mind. The door being open so that my husband could see in represents my discussing my problems with him so that he knew what was going on inside my mind. The fact that he did not seem interested in helping me make the light burn represents his recognition that this feeling I had for you was not a healthful one and needed to be overcome. I think my continuing to use the room to comb my hair represents my desire to keep the feelings I had toward you. But though I realized I could not make that one light burn I consoled myself with the thought that I could make others burn. I do not know for sure what this means. The only thing I can think of is the fact that I get much more notice from men now than I did during the years I was most ill. I do not mean by that that there is anything that is not acceptable to my husband as well as to me, but for a long time I was pretty well ignored by men. They were polite to me but that was all. I think the lack of notice was caused by the same thing I mentioned to you one time, namely that I felt badly all the time and looked distressed. Now I am happy. I can laugh and joke and have fun and every once in a while I chance to say something they apparently think is witty. My husband includes me in lots of things he formerly did not. And he seems to enjoy my being with him when other men are around. For instance, there may be two or three men in his office laughing and talking with him and he will ask me to come in, too. It has been a good many years since he did that, because I always felt bad and I guess I put pretty much of a damper on things. That is what I think that part of the dream meant, not that I could make men fall in love with me but that though there was one whom I could not even see I was not unsuccessful with everyone. It is embarrassing to me to tell you that there were times when I wanted very much to have you be interested in me, and you were completely successful in maintaining a doctor-patient relationship, which of course was right. To tell you this dream at all has been embarrassing to me because of the significance in other dreams which we discussed of turning on a light." [In these dreams a burning light was identified by her as symbolic of an erect penis.] "I debated a long time about including this one but finally felt that I really should because it was a dream that stayed on my mind until I worked it out. I would not work on it for a long time, but I could not quit thinking about it until I did. This dream and interpreting it was useful to me for it made me realize the truth of how I had felt toward you and it made me face facts so that I did begin to realize that I had a neurotic attitude toward you. With the recognition and admission in my own mind I made the first step toward overcoming the difficulty."

The patient concludes her discussion of the resolution of the transference by saying, "The unreasonable desires toward you have left and there now remains only a normal feeling of gratitude and devotion. The feeling I now have is that which I can express freely to anyone with no sense of there being something I must hide."

Specialized Hypnotic Techniques

1. *The use of dreams.* It will be recalled that one of the patient's original complaints was of frequent disturbing dreams. In addition to working with spontaneous dreams, these two ways of "producing" dreams were used, one by suggestion that clarifying dreams would take place that night, and the other by suggestion that "dreams" would appear during the hypnotic sessions. Dreams were suggested when the material seemed to be digressing from the main theme, when a clearer statement of the theme was desired, and when an equivalent dream was wanted to help interpret a dream which either the patient or the therapist was having difficulty in understanding. The dreams obtained were handled, in addition to the usual techniques of association and interpretation, by forcing the recall of forgotten elements and by insisting on a clearer view of obscure details.

An example will be given of a dream suggested after a period in which there was a digression initiated by the therapist who wanted to know more about the patient's sensations during induction and in the hypnotic state. The patient was told that she would dream a dream that night which "would return us to the main theme." She reported in the next hour, the 51st, the following dream:

Her father is seen sitting in the living room on a chair. He has no clothes on. He is apparently ill, looks emaciated, but is laughing and talking. She is bathing him, she wants to avert her eyes from his body but cannot because she has to bathe him. This, she feels, makes it all right to look at him. He tells her to hurry because she has to go to church. She goes to church with a man whom she doesn't know but in whose company she takes great pleasure. She had hoped to get to church early to rehearse something but finds to her annoyance that there are already many people there. Something is wrong with the lighting in the church. She attempts to replace a fuse but is unable to do so.

Her associations to this dream seemed to make it clear that it represented a sexual wish for her father and for the therapist. The matter of bathing her father refers to caring for him in his last illness when she saw his penis. The man whom she takes to church is the therapist. He has to go there because she feels that the therapist is not sufficiently religious, and to overcome the fact that he is a Jew. Her hopes to have the church empty and the difficulty with the lighting would provide an opportunity for sexual contact.

The patient had difficulty in understanding the above dream despite the fact that it was worked on for several hours and therefore the next device to be described—the suggestion of an equivalent dream—was used. The patient was told that she would have a dream that night which would express the same thoughts more clearly. The next day she reported two

dreams, though she said she didn't see how they could be related to the dream of her father and the church.

She is marrying a "part Negro." She knows that she has been married before and that her name is X——. She likes her husband-to-be very much but doesn't want any of her friends to know about it. In the second dream she is again being married, this time to a man by the name of Dumbowski. This time, too, she knows she has been married before and so has he. Dumbowski is a south-European of some kind and gives the impression of being a large man even though he is not very tall. Not until the next hour did the patient admit that in the dream she had intercourse with Mr. Dumbowski.

The south-European "half-Negro" is easily recognizable as the therapist. The patient immediately associated to the fact that the man was large, though not tall, the idea that this was just the feeling she had about her father and when she nursed him in his last illness she was surprised to see how lean he was. This was a link to the bathing scene of the preceding dream. The frankly sexual character of the dream about Dumbowski was then clarified and made it possible for the patient to accept and understand the dream about father and the man whom she took to church as a (sexual) wish for father and therapist.

Next will be described a dream suggested during the hypnotic hour. The example chosen is a dream suggested to elucidate another dream. In the 108th hour the patient reported this dream:

"I go into a shoe store, see a hat, try it on, think of buying it and decide not to, buy something else and leave the store. I then look at my purchase slip and realize that I was charged for the hat even though I did not buy it. I am outraged." She was asked to re-dream the dream in hypnosis and this time added to it that she did not return to the store but walked down the street, descended some stairs, and came to a place that was like a sunken garden.

Though the sexual symbolism of the dream is obvious, questions as to its meaning brought little response. (Incidentally this point is worth noting because it offers evidence contrary to the idea that in a good hypnotic subject symbols in dreams can be always readily interpreted.)

In the next hour it was suggested that the patient dream another dream which would express the same idea. She did, as follows:

"I am walking down the street and feel big and powerful like my younger brother (a husky six-footer). I come home, look in a mirror, and am disappointed to see myself as I am."

The hat and the sunken garden, then, are respectively her wish to be powerful and have a penis like her brother, and the reality that she is small and a woman. That she paid for a hat but didn't get it indicates her hope to get a penis from the treatment, though of course this was not made any clearer in the equivalent dream than in the first.

We will now discuss several techniques of working with dreams which are possible in the hypnotic state in addition to the ones usually employed in the waking state.

First will be described forcing the recall of forgotten portions of the dream. A dream is often forgotten in part or in full because it was too illuminating, having too completely escaped distortion. Its recovery would therefore be especially useful. In the 38th hour the patient reported this dream:

"I go to a tourist camp with my husband. I seem to know that this camp is used for immoral purposes. I go into one of the cabins with my husband who asks me to undress. There is some difficulty in drawing one of the blinds and my husband says it doesn't matter. I undress and become sexually aroused but my husband leaves me unsatisfied." The patient was sure there was another part of the dream which introduced it but had been unable to remember it. She was told that she would recall it at the count of 10 and did so. She then remembered that *"as my husband and I come to the camp a man who seems to be a manager is drawing pictures on a blackboard before a group of people."* She thought these pictures might have been of nudes.

There was then introduced the next technique to be described, that of forcing a clearer statement of details of the dream. It was insisted that the patient "look at the drawings" and describe them, as well as to identify the artist. The patient described the picture drawn as one in the Thematic Apperception test, one of the tests given during the diagnostic study, and the man drawing the picture was the psychologist who administered the test. The picture was of several scantily-clad people. The patient had been unable to tell the psychologist any story about this picture and felt that he would deduce from this the fact that she was disturbed about sexual matters. The details of this forgotten part of the dream then made it much easier both to interpret the dream and to lead the patient inescapably to the fact that the dream represented the patient's view of the treatment situation which she had erotized and in which she had felt frustrated by the therapist.

Still another way of working with dreams was described in a previous paper from this Clinic[1]. In that case the patient was told to finish in hypnosis an incomplete dream. This device was not used in this case.

2. *Regression.* Hypnotic regression techniques played a significant role in the last quarter of the treatment. Two ways in which regression was used will be described: first to reproduce the initial appearance of a symptom, and second to strengthen insight by reproducing a time at which ideas deduced from the material were consciously present in their original form.

Regression to reproduce the initial appearance of a symptom is illustrated

by the following episode: several times during the treatment the patient had talked about a peculiar feeling in her face. It seemed to be growing and her face and lips felt very thick. In the 106th interview—by which time her penis-envy had been well understood—she again reported this feeling. All she could associate to it was that she believed it began during either her first or second pregnancy. The patient was regressed with the instruction to return to the first time this symptom had appeared. She went back to the fifth month of her first pregnancy and described the feeling as being present. The request to directly interpret the symptom was fruitless and she was told she would have a dream and did so as follows: the dream was apparently a memory.

"It takes place at the beginning of my first pregnancy. I am sitting in the living room at home, my husband comes in and takes me on his lap, pats my face and says: 'You may be little now but you will grow. The baby will grow and you will grow too.'"

Since the patient already understood the significance of being small was to her being without a penis, it was easy to infer that this feeling of growth relates to growing a penis. This interpretation was difficult for her to accept, however, and she obviously had no emotional conviction about it.

This conviction was produced by the second use of hypnotic regression to be described, a return to a time when the fantasy of growing a penis might have been conscious. Since there had been much evidence that the patient associated menstruation with a genital injury, she was regressed to her first menstrual period. She said that at first she thought the blood came from her kidneys but now she thinks some little piece of flesh had been torn and was bleeding. She had imagined that she might grow a "wetter" like boys have, but now the little piece of flesh which might have grown into one was torn. She remembers reading a story in which a princess was turned into a prince and hoping that a fairy would wave a magic wand over her and turn her into a boy. She remembered that she and her brother would go out on the back porch to urinate and she would stand up to emulate him. She would pretend that she was holding her penis in her hand. All these ideas were expressed spontaneously in approximately these words.

The patient had been regressed to her first menstruation eight hours earlier in the treatment. At this time too she had expressed the idea that something tore and bled, but she went no further. In the hours between the two regressions to her first menstrual period the idea of growing a penis had first been introduced. It may be then that it was this which allowed such material to emerge spontaneously in the second regression. It might of course be objected that this was the result of suggestion. The question cannot be answered other than by pointing to the internal unity of the

material or by taking up the general problem of the validity of hypnotic regressions.

3. *Specific Explorations.* As we have already reported in a previous paper[1] and as has also been clear in this one, the use of specialized hypnotic techniques implies a good deal more activity and direction of the treatment by the therapist than is usually the case in a psychoanalysis. One of the advantages that this possesses is that the therapist can direct the material by deciding which trend he wants to explore further, choosing an episode in the history in which this trend seems to come close to the surface and then pursuing this by one of the special hypnotic techniques. For example, after this patient's penis envy and disappointment that she did not grow one had been worked through it was decided that she needed to understand something of her castrative wish toward men. The episode six years before in which she had had to fight the feeling that she would stab herself seemed to mean that she was reacting with guilt for a castration wish and hence felt impelled to cut herself. The patient was regressed to this episode and it was found that her conscious thinking at that time was that she considered her illness was ruining the lives of people about her and she should therefore kill herself. It was suggested that she dream in the regression about the fear of knives and she dreamed as follows:

"A surgeon tells me, 'I will cut and cut and cut, so that you won't have to kill yourself.'"

This was the first of a series of suggested dreams in which the following sequence of ideas appeared: First the patient felt that her genitals were torn by childbirth, then she dreamed of harm coming to her son which she seemed powerless to prevent though she was willing to sacrifice herself for him, and then clearly castrative wishes against men appeared as seen finally in the dream which has already been mentioned in which a man did something to her from behind and left his penis in her. In one of the very last hours the patient, regressed to the age of eight, expressed the fantasy of cutting off her brother's penis with a pocket-knife and sticking it onto herself.

4. *Forcing Recall and Interpretation.* In this case we used for the first time a new technique for getting answers to questions in addition to those described in a previous paper. The patient was told that she would write on a blackboard in her mind and that she would not know what she was writing and would be unable to read it until it had been entirely written. On a number of occasions she would produce no associations to a dream or an idea when directly asked to do so, but relevant and revealing material could be obtained by use of this blackboard technique. Often she would have to be urged quite insistently before she would read what she had written. This technique is likely related to automatic writing. It is as

though the material escapes censorship more easily because it is not recognized in consciousness while it is being produced. But because a record is made, in the case of automatic writing on paper and in this technique on an imaginary blackboard, this record can be presented to consciousness which must then face interpretation.

5. *Direct Suggestion.* Hypnosis was occasionally used as a medium for direct suggestion for the temporary alleviation of symptoms. There were periods in the treatment when the patient's headaches were severely exacerbated, obviously in relation to disturbing material. Weekends, during which she had no treatment hours for two days, were often extremely difficult for her because of headaches. It was therefore occasionally suggested that she be free of headaches during the weekend and that "instead your subconscious mind will work out a dream which will help you understand your problem." One one occasion the patient graphically reported her sensations after such a suggestion as follows: "It seemed as though a dam had been erected in my mind to hold back a body of water. Every now and then there would be a gust of wind that splashed a little water over the dam and I would feel a twinge of pain, but then I would think to myself that I was not to have a headache and it would go away". There was never any evidence that the use of hypnosis in this way blocked the flow of material.

Discussion

One of the noteworthy features of the case data is the almost exclusive preoccupation of the patient with so-called phallic material. It is probable that this is to a significant degree accounted for by the essentially hysterical nature of the illness. The personality development had apparently been basically sound, complicated only by the relatively circumscribed problems disclosed. But, to some extent, the relative absence in the patient's productions of material concerning problems other than phallic ones may be ascribed to the treatment method. Since the therapist was able to hold the patient to the problem at hand, digressions were relatively infrequent and this may have prevented the appearance of more material from other psychosexual levels, especially under the hypothesis that such material would arise as a resistance against the resolution of the regnant (phallic) conflict.

Another outstanding feature of the case data is the rapid translation of the patient's problems into their earlier childhood forms; the feeling of inferiority to men, for example, was first stated as inferiority in size, education, and opportunity but was soon translated into a feeling of inferiority because of the lack of a penis. Of course this regularly occurs in psychoanalysis but usually not so promptly. We would like to discuss several

possible reasons for this quickened tempo, one more specific to this case and the other more generally applicable to hypnoanalysis.

The specific reason results from the fact that to this patient hypnosis meant the possibility of a realization of her fantasy of masochistic sexual surrender to a father-figure. Since this fantasy was an expression of one of her leading conflicts, the transference relationship almost at once duplicated the original neurosis, which then quickly appeared in its earlier form. It is also possible that the patient's wish for a penis, a hope frequently unconsciously entertained by women analysands, was here able to come more quickly to expression because of the magical power the patient ascribed to the hypnotist.

The reason generally regarded as chiefly responsible for the relative rapidity with which earlier and unconscious forms of the patient's conflict are revealed in hypnoanalysis is the circumventing of resistance in the hypnotic state. We would like to take up two frequently stated objections to hypnoanalysis which follow from this circumvention of resistance.

The first objection is that the failure to analyze the patient's problem in all of its current and conscious manifestations before plunging into its earlier and unconscious forms means that those manifestations not touched upon will remain unresolved and continue to give rise to symptoms. Against this objection is the fact that the patient reported in follow-up letters the disappearance of attitudes which had not been touched upon in the treatment. For example, she wrote that while nursing her son during an illness several months after her return home she suddenly realized that always in the past when she had mothered him she had felt strange and foreign, but that now this feeling of strangeness had disappeared. This feeling of strangeness was of course one manifestation of the patient's rejection of femininity, though it was never mentioned during treatment. It disappeared concomitantly with the general change in the patient's attitude toward her femininity.

The second objection is that hypnoanalysis can effect only very incomplete insight because it eliminates defenses instead of analyzing them. It is certainly not true that hypnosis eliminates defenses. It can weaken them and that only sometimes. More than one hour was spent in this case in a fruitless insistence that a particular dream symbol would be clarified or even that a particular dream would be recalled. The defense mechanism which seems to yield most readily to hypnosis is repression and it may be for this reason that hysteria—the neurosis in which repression is the dominant defense—is especially amenable to hypnoanalysis. Defense mechanisms can be analyzed in the hypnotic state just as in the waking state, and, with the material made available through the lifting of repression, perhaps more easily. How the hypnotic state affects defenses other than

repression is an unexplored problem. If a patient in hypnosis can directly state the meaning of a dream, surely this means that the various defenses employed in the distortion of the latent dream thought have somehow been altered.

With one incidental exception, the interviews with this patient were carried out entirely in the hypnotic state. This presents a very different picture of hypnotherapy from the sometimes described procedure in which material is obtained while the ego is held in abeyance and the material must subsequently be presented to the waking ego for any integration that takes place.

It is sometimes stated that the forcing of repressed material to consciousness would not be desirable even if it were possible because the unprepared ego would be unable to bear the anxiety provoked. The use of the technique of direct suggestion is a means of counteracting this anxiety. This patient responded very well to the suggestion that she would not consciously be concerned with her problems over the weekend, for example, and, as already described, her headaches were also sometimes handled in this way. We believe that the hypnotic relationship itself affords gratification and reassurance to the patient, since the therapist to some extent takes on himself the onus of responsibility for the material produced even though the patient must later accept the material as her own.

Another objection which has been raised against the forcing of repressed material into consciousness is that while this may lead to intellectual acceptance, emotional conviction is lacking. In this case, however, the recovery of repressed material was accompanied by profound and appropriate affect, so that the hypnotic state appears to effect circumvention of the repression both of content and of affect. We have already discussed the use of regression to strengthen emotional insight.

A previous paper from this Clinic[1] has pointed out that a differentiation must be made between the changing transference manifestations as they take place during the course of the treatment and the relatively constant transference relationship which we assume to underlie the hypnotic state. That is, we assume that hypnotizability is essentially to be understood as a transference phenomenon and that a particular person can be hypnotized because the hypnotic relationship gratifies an unconscious fantasy or a wish, though this fantasy may vary from subject to subject. We had further assumed that in the course of hypnoanalytic therapy this fantasy could be explored and we would then know the basis of hypnotizability in this particular subject. We feel now, however, that a distinction must be made between the underlying basis of hypnotizability in a particular person and the meaning of hypnosis to that person. It is true that in a hypnoanalysis one can discover the meaning of hypnosis for a particular patient. It was

clear in this patient that the hypnotic relationship meant a situation in which her masochistic fantasies might find expression, but it does not necessarily follow that this was why she was hypnotizable.

We feel that the distinction is of importance because it is of methodological significance in pursuing the question of the basis of hypnotizability. If hypnotizability were based on the gratification of a fantasy it might follow, for example, that the elucidation of this fantasy would lead to a change in the degree of hypnotizability. It has even been suggested that a "thoroughly" analyzed person would no longer be hypnotizable. It seems doubtful to us that even after a relatively prolonged and thorough analysis the basic unconscious fantasies are so altered that a previously existing hypotizability would no longer be present. Certainly in this particular case the question cannot be decided if for no other reason than that the masochistic fantasies were only superficially explored.*

An undiscussed problem is the nature of the dreams which appear after direct suggestion in hypnosis, both those that take place that night during sleep and those that take place immediately in the hypnosis. Whether these dreams have any special characteristics and how they compare with ordinary dreams as well as the bearing of these hypnotically suggested dreams upon the problem of the relationship between hypnosis and sleep are unexplored problems.

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* Although this topic cannot be pursued any further here, it should be pointed out that Kubie and Margolin have proposed a theory of hypnotizability which takes account of the transference phenomena existing in the hypnotic relationship without at the same time ascribing the hypnotizability to these transference phenomena.[2]

RE-EDUCATION AS A THERAPEUTIC AND PREVENTIVE TECHNIQUE*

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In March of 1945 we were informed by the Surgeon General's Office that U. S. Army patients were arriving from overseas at the rate of about 1,200 a day.[1] About 40 per cent of all patients evacuated last year suffered from mental and emotional disorders.[2] The significance of mental illness has been cast in bold relief by the war. Brig. Gen. William C. Menninger, director of the Neuropsychiatry Consultants Division, Office of the Surgeon General, recently reported: "We found that 39 per cent of all men rejected at induction were suffering from some type of personality disorder—1,825,000 out of a total of 4,650,000 men."[3] Furthermore, 43 per cent of all medically discharged—even after the screening out of draftees—were discharged for neuropsychiatric reasons.[4]

These reports are shocking to a public that has coasted along for many years with an all-pervading problem of maladjustment in human relations. Now belatedly we are brought up short by its significance in relation to the war effort. What, apart from the war has maladjustment meant to us?

Cost and Scope of Mental Illness

In 1940 there were as many as 188 state and federal hospitals for mental disease.[5] In addition to this, there were 27 veterans' hospitals, 80 county and city hospitals and 187 private hospitals providing psychiatric wards for those who are mentally ill.

* An address given substantially in its present form before the 60th Annual Meeting of the Allegheny County Children's Aid Society, June 7, 1945, in Pittsburgh, Pennsylvania.

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[1] Bulletin, U. S. Army Medical Dep't. No. 88 (May, 1945), "News and Comment", pp. 5–7.

[2] Woodward, Luther E., "State and Local Planning in the Light of Federal Provisions and Clinical Experience," in a symposium, "Psychiatric Rehabilitation of Rejectees and Men Discharged from the Armed Forces." *Mental Hygiene*, Vol. 29 (Apr., '45), pp. 261–268.

[3] "Unemployment and Mental Health," p. 7. Mimeographed. Washington, D. C.: Office of the Surgeon General, Aug. 24, 1945. Cf. also *Wartime, Health and Education*, Interim Report from the Subcommittee on Wartime Health and Education: "Health Needs of Veterans," Feb., 1945. Washington, D. C., U. S. Gov't Printing Office, 1945, p. 11.

[4] Ibid., p. 8.

[5] Unless otherwise documented, the cost and scope of mental illness here presented is based upon *Patients in Mental Institutions*, 1940, U. S., Department of Commerce, Bureau of the Census.

For the same year, a total of well over a half million were mentally ill to the degree of requiring hospitalization. To make these figures more meaningful, we may say that at the end of the year 3.6 persons per thousand of the total population had been in mental hospitals. There were more psychiatric patients than all other patients combined. Since 1932 there has been a steady rise in the numbers of those who have entered hospitals because of mental illness.

We might put it this way: the United States has set aside hundreds of hospitals, many thousands of highly trained personnel, and $150,000,000 annually in order to provide care and treatment for its own mentally ill. Mind you, this is only the program for the mentally deranged, not for the mentally defective and epileptic, which program in itself requires an annual expenditure of over $30,000,000.

Cost and Scope of Crime

Nor does it deal with the cost of crime, which is now rightly regarded as another face of our maladjustment Janus. The cost of criminal justice alone is well over $250,000,000 annually.[6] But if we consider the cost of state police forces, state penal and correctional work, private detective service, armored car service, fraudulent use of the mails, insurance against crime, federal criminal justice, and the loss of productive labor of prisoners and officers, we get the huge sum of $842,766,000 per year. Yet this sum by no means covers the whole public cost of anti-social, illegal, and aggressive acts of maladjusted individuals who sooner or later get into the hands of the law. The cost of juvenile delinquency and other related problems is not included in this estimate; nor is the cost of property damaged, destroyed, or stolen. In fact, students of the problem estimate the total cost variously between 10 and 18 billion dollars annually.

Nearly 700,000 human beings pass through prison gates each year.[7] These are short-term prisoners. The long-term prisoners number about 150,000, and occupy 113 federal and state prisons and reformatories. The annual cost of administering these large institutions is about $30,000,000. The investment in buildings, land, and equipment is about $100,000,000. If we exclude the young offender and confine our statement to crime alone, we may say that the United States sets aside hundreds of prisons, many thousands of highly trained personnel, and actually billions of dollars a year to handle the problem of maladjustment as reflected in crime.

[6] Morris, Albert, *Criminology*. New York: Longmans Green and Co., 1938, pp. 20ff.

[7] Tannenbaum, Frank, *Crime and the Community*. New York: Ginn and Co., 1938, p. 292.

Cost and Scope of Maladjustment

Surely, the number of our seriously maladjusted citizens is tremendous. We have over a million of them at any given time. The waste and tragedy is overwhelming, more so because nothing we have said so far has dealt with prevention. Involuntarily one asks, What can be done about prevention? Is it possible, during the incipient stages, to recognize and prevent serious maladjustment leading to incarceration, either in hospitals or penal institutions?

Early Recognition of Maladjustment

Some time ago I served as a consultant on mental hygiene problems in a city in Kansas at a Pre-school Round-up. Here mothers or fathers brought their children, aged three, four, and five for a physical examination. A doctor from the Public Health Department examined these pre-school children and did an excellent job of health education with the parent, who stood by. Approximately 100 children were examined, and of these, fifty were sent to my office because the parents had questions concerning various psychological problems. Thirty of the parents with whom I consulted had adjustment problems which were not of a serious nature. With the help of specific suggestions, these could be solved, at least temporarily. Fifteen parents were seriously in need of help. They were neurotic and anxious, overprotective, overindulgent, or rejecting of their children, and their children exhibited the usual withdrawn, aggressive, or negativistic behavior. Upon interviewing these parents, I became convinced that they needed periodic counseling, not just this one half-hour with me. I felt that without it their children were likely to become neurotic adults.

Five of the fifty parents presented such a picture of inadequacy, and their children such a picture of maladjustment, I felt hopeless about counseling with them at all. If the children of these parents were to have a chance at a life of productivity and happiness, the parents would need daily counseling from a specialist—one who could provide specific suggestions as well as a therapeutic approach in his relationship. At the same time the children would have to have intensive treatment for many months. Without such treatment these children were doomed to unhappiness and were likely to spend their lives separated from society in a legal or psychiatric institution.

Maladjustment does not wait to show its head until adulthood but can be detected during incipient stages. It is true that the child is more easily kept in hand than is the adult, and it is true that children under the age of fifteen are rarely separated from society because of their antisocial behavior. Yet, the pattern of their behavior is essentially similar

to the adult. Indeed we can tell where they are heading. Fortunately, we know what they need.

Re-education Techniques

The special treatment of maladjusted children is basically a process of re-education. These children have acquired many asocial and antisocial habits that should be unlearned, so to speak, and should be replaced with desirable, acceptable habits of living. The process is made possible by various kinds of therapies and psychiatric skills not found in mass education or the public school system. At this frontier stage these are limited to individuals who have specialized in the various ways of using positive techniques in dealing with children. By positive techniques is meant behavior on the part of an adult that helps the child satisfy his wants. It can be supported by research that when teachers are encouraging, praising, agreeing, responding favorably, giving balanced criticism to children, they will, almost without exception get desirable responses from them.[8] This is one of the basic principles that underlies psychotherapy, education therapy, recreation therapy, manual arts or occupation therapy, companion therapy, and group therapy.

Sometimes a child is so disturbed as to be unable to get along with anyone except some specially chosen companion, who, by continual support, encouragement, and positive behavior, gradually serves as a reassurance that he need not fear or hate other people. Some children require psychotherapy. Such treatment provides the child with opportunities to express himself through words, play, or various activities, and gradually gives him assurances, understandings, and abilities to meet first the minor, then the major frustrations of ordinary living.

Illustrative Cases

Some such special treatment has been provided at the Southard School, from whose files I have selected three cases for illustration. The first of these is that of a 13-year-old boy who was admitted to Southard School after he had been expelled from several private schools and had become completely unmanageable at home, at school, and in the community. The father had not wanted children. The mother, a very high-strung, inconsistent but kindly person, had insisted upon having a family and had followed her husband from city to city, wherever his work required him to live. By the time this boy was thirteen he had attended 14 different schools. At the age of eight, he had had an accident, following which he was hospitalized for several days. Once he overheard the family discussing his condition, and he believed that he had some sort of a brain disease. His behavior was marked by periods of deep depression and comments that he was no good and might as well die. At times he was very active and uncontrollable in swearing, boisterousness, hitting people, lying, stealing,

[8] Diane Belogianis, Harriet Kymer, Anna J. Lukes, and John B. Geisel, "Positive Techniques in the Classroom," *Elementary School Journal*, June, 1944, 594–601.

and refusing to do school work. He picked on the younger children but was cowardly with children his own age. When he began at Southard, he could not tell time, and, at the age of thirteen, his placement was second grade.

Treatment in the School

After a month of hostile and aggressive behavior which was accepted without punishment or fault-finding, this boy was given tutoring in all subjects at the grade level he could manage. Teachers encouraged him at any sign of accomplishment. Besides the academic work, he was given extra time in the shop and had a special period with the music therapist with whom he could sing cowboy songs to his heart's content. A complete clinical examination revealed that there was no indication of any "brain disease," and the boy was assured of it by his psychotherapist, who saw him daily. Encouraging findings of this nature, plus the effect of an environment of acceptance, led to rapid progress in school work and the surprising conclusion that perhaps, after all, he wasn't dumb and could get along as well as other boys.

Boarding Home Care

After four months of residence in Southard School he was placed in a boarding home, where he made an excellent adjustment, and continued his class work at Southard School. In less than two years' time he covered all the arithmetic from the second through the sixth grade and all required work in other subjects. He then enrolled in public school, seventh grade. His expertness in model airplane construction, carried on as a hobby with the help of one of our staff members, was outstanding for a boy of his age. He not only learned that he could do as well as other boys, but in this field he was even more skilled than they.

At this time the family moved to Topeka and established permanent residence on recommendation of the Staff. The boy moved into his own home, and both the boy and his mother received treatment during the initial period of their reunion. He concluded his first year in public school with above average grades in all subjects. He got along well at home, continued his interest in model planes, and was well accepted by the boys of his age in the neighborhood. After two years of re-education his promise of forty years of productive citizenship was now as good as that of any other boy.

Case 2: The second case is that of a fifteen-year-old step-daughter of an attorney. The girl's own father had died when she was quite young and her mother had not allowed the step-father to have any control of the girl, even though she herself was utterly unable to cope with the child. This girl was physically attractive and wore black, form-fitting, slinky dresses and wide, broad-brimmed hats. She was extremely affected in her manner, tried to act like a woman of the world, and was seductive toward all the boys in the school and the male staff members. Thoroughly spoiled, she became hysterical whenever her demands were frustrated. She often threatened to run away. She persistently told lies. She had made several attempts to attend schools, but after a few months she would refuse to go back to classes. Her mother was utterly helpless in her management and had been giving in to all her demands.

Progress in Re-education

Soon after admission to the Southard School, intensive psychotherapy by a child analyst was undertaken. Meanwhile, tutoring enabled her to complete a number of unfinished subjects and get credits without doing all work over again. She was a

brilliant child and responded well to the tutoring. Six months later she was enrolled for two classes in the public high school; the following semester she took a complete course in public school. At this time she was placed in a boarding home where her home management was supervised by a social worker and from where she came daily to the Southard School for treatment. There were no other children in this home and the foster mother was a dominant but kindly person, who gave the girl considerable affection but did not allow her to get by with anything. In this boarding home she learned how to get along with adults, and her behavior gradually became less objectionable. She stopped wearing clothes that emphasized her figure and assumed the usual bobby sock wardrobe of the high school girl. Her lying decreased. She developed some friendships with girls and boys of her own age. She did excellent school work throughout the year and has since returned to her own home. Recent reports are that she is doing well in public schools, and the family is happy to have her back.

Case 3: The third illustration is that of a sixteen-year-old boy, the son of a well-to-do manufacturer on the East coast. He was a very handsome, heavy-set, well-built youngster, with a high I.Q. He had rejected his mother so completely that he refused to address her in any way and had simply withdrawn from the family. He had failed in private schools for two years and exhibited a complete lack of interest in everything. When he entered Southard School he went around with a moody, sulky manner and talked to no one. He refused to enter into any school activities and spent most of his time by himself. When he met other boys at the drug store or at the show he was rude, pushing and shoving them around.

His father was a passive, soft-spoken person who had never had a great deal to do with the rearing of his children. The mother had spent most of her married life with interests outside of her family.

Psychotherapy

Soon after admission to Southard School this boy was scheduled for an hour daily in psychotherapy. He kept his appointments, but for a period of two months did little more than shrug his shoulders and say that nothing mattered to him. He was also enrolled in the public high school for a full course of study.

Later, in a foster home he was accepted on an adult basis. The foster mother was an active young person, who was not maternal but who developed a sisterly relationship with the boy. Here he became talkative. He began to dress up, whereas formerly he had slouched around in blue jeans, his shirt hanging out. He went with the foster family to the homes of their friends on ice-skating parties, picnics, and other social activities. He became more friendly with staff members, and much more productive in psychotherapy. He made excellent grades at the high school, developed friends among the boys, and began having dates with high school girls. In eighteen months he returned home and attended a private school from which he was graduated the head man in his class.

Present Facilities for Re-education

We are confident in our belief that re-education, serving as a great preventive measure, is effective in modifying or curing maladjustment that has crowded our institutions with adults, sapped our manpower by millions, robbed our treasuries by billions. Yet, present facilities for a re-educational program are almost non-existent. With the exception of a very few

psychiatric treatment centers, there is almost no provision in this country for preventive treatment of children whose maladjustment virtually predicts institutionalization.

The crying need is for a re-educational program for children of average or superior mental ability and a preventive attack upon the problem of maladjustment that leads to crime and mental derangement.

The Prospect

And since the need is more clearly felt these latter years than it has ever been felt before, we truly stand on a frontier in the educational scene. The new field to develop is re-education for parents and children. We are on the threshold of an era in which prevention of mental illness and crime is to be emphasized through re-education centers in every state, very likely in every community of size. The time will come when public school teachers in all of our schools will borrow much from the techniques employed in these re-educational centers. Eventually, psychiatric treatment facilities will be part and parcel of our entire school system.

THE VETERANS CLINIC OF DETROIT

One year ago (July, 1945, Vol. 9, No. 4) the Bulletin carried an account of one of the earliest community clinics for veterans, the San Francisco Veterans Clinic under the direction of Dr. Emanuel Windholz and the late Dr. Jascha Kasanin.

Another very successful veterans clinic, also using the volunteer services of a group of psychiatrists and psychiatric aides, has been established in Detroit for nearly a year and a half. We are presenting here some excerpts from the annual report of the director, Dr. Leo H. Bartemeier, with his permission. —The Editors.

The Veterans Clinic of Detroit was established at Harper Hospital on February 6, 1945 for the purpose of providing psychiatric treatment for veterans of World War II. This Clinic was sponsored by the Michigan Society of Neurology and Psychiatry, and was financed by the War Chest of Metropolitan Detroit. It was approved by the Council of the Wayne County Medical Society, the Michigan Society for Mental Hygiene, and the State Office of Veterans Affairs. The Executive Committee of the medical staff of Harper Hospital provided adequate facilities for the use of the Clinic.

Professional Staff

Fifteen psychiatrists volunteered their services under the direction of Dr. Leo H. Bartemeier, who had assisted in initiating the program. They offered to work with patients two hours on a specified night each week. Many of them have contributed additional professional services in their private offices. Two psychiatric social workers volunteered to work with Miss Barbara Boger, the Administrative Assistant, in the taking of histories and in case work procedure. Several neurologists, neuro-surgeons, and psychologists offered their professional services. The physicians working in the Out-Patient Department of Harper Hospital offered to study patients referred to them by the Clinic for consultation.

Procedures

The Clinic is open from 9:00 o'clock in the morning to 5:00 o'clock in the afternoon on Monday through Friday, and on Tuesday, Wednesday, and Thursday evenings from 6:30 to 9:30. Doctor Cavell is on duty each morning from 9:00 o'clock until 1:00 o'clock in the afternoon, and, in addition, volunteers his services each Thursday evening. A volunteer social worker is on duty Tuesday, Wednesday, and Thursday evenings for the purpose of taking histories and assisting in therapy with patients who cannot come during the day. An average of seven psychiatrists are working each Tuesday, Wednesday, and Thursday evening.

When a veteran comes to the Clinic for the first time he has an initial interview with the social worker, during which his medical and social history is obtained. On his second visit to the Clinic he has his first interview with the psychiatrist and he continues in treatment with him for periods ranging from 30 minutes to one hour. In some instances veterans are referred to the social workers for therapy under

the direction of the psychiatrists. Relatives of patients are interviewed whenever this procedure is advisable.

Veterans who are in need of prolonged hospitalization are referred to the Veterans Hospital, and the Clinic assists in arranging for their admissions. In other instances in which intensive therapy for a period of a few weeks is indicated, the Clinic arranges for the veterans' admissions to the Veterans Readjustment Center at the University Hospital in Ann Arbor. On a few occasions the Clinic has arranged for patients to be hospitalized in a private mental hospital.

Professional Standards

Throughout the year the professional staff has met regularly every fortnight, and more recently once every month for general discussion of scientific and organizational problems.

Observations

This annual report would not be complete without some observations which have been made during the past year. The Clinic has grown rapidly. Twenty-two psychiatrists are now working with patients each week. In June 1945, the War Chest increased its appropriation for the services of a full-time psychiatric social worker. Through the assistance of Colonel Philip C. Pack, the State Office of Veterans Affairs financed the services of Dr. Roscoe W. Cavell, formerly psychiatrist to the Ninth Army. The State Office of Veterans Affairs made it possible for the Clinic to have the services of a typist-clerk and a psychiatric aide. Additional offices for physicians were provided by the Executive Committee of the Medical Staff of Harper Hospital.

Prior to the establishment of the Clinic the view was held by some that returning veterans would be primarily interested in obtaining compensation and that they would be lacking in a wish to recover from their disabilities. There were those who thought that so long as veterans were receiving disability compensation this would interfere with the success of therapeutic efforts. The Clinic has now been in operation for a year and it has been the experience of everyone on the professional staff that the veterans who have turned to the Clinic for assistance have consistently shown a wholesome interest in recovering from their illnesses. The psychiatrists working in the Clinic have not observed that disability compensation has acted as a handicap in the therapeutic process.

When plans were being made to organize the Veterans Clinic there were a number who expressed the view that psychiatrists who gave their professional services on a volunteer basis would soon lose interest in their work with patients. After one year, everyone is impressed with the diligence and continuous interest which the psychiatrists have displayed.

The Veterans Clinic has received wholehearted cooperation from all of

the social agencies and other organizations throughout the City of Detroit. Much of the consistent interest on the part of the volunteer staff derives from the realization of the great need for this specialized professional service and the splendid response from the veterans themselves. The fact that fifteen psychiatrists began working in the Clinic one year ago and that this number has now increased to twenty-two manifests their continuing interest in providing assistance for veterans with psychiatric disabilities.

Referrals

Of a total of 405 veterans admitted for treatment in the first year, the statistical report shows that, in the first months of its operation the largest number of patients were referred by the Veterans counseling centers and other social agencies. The experience of recent months shows that the larger number of veterans are being referred by veterans who previously came to the Clinic for treatment, and through the publicity in the local press. The statistics show that the majority of veterans who have consulted the Clinic are unskilled or untrained workers and that only 20 percent had combat experience. The figures likewise show that only a very small number of the veterans who have visited the Clinic have been in need of hospitalization.

Needs

Now that the Clinic has become much better known in the community and the number of veterans coming to the Clinic for assistance has gradually increased, there exists an urgent need for the services of an additional psychiatric social worker and a clinical psychologist. It has been the policy of those directing the activities of the Clinic to maintain high professional standards and to provide the veterans with the same quality of care that they would receive as private patients from practicing psychiatrists. In order to maintain these ideals, it is essential that sufficient professional personnel be available at all times.

From the Annual Report of the Director,
LEO H. BARTEMEIER, M.D.

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THE SENSE OF WELL BEING AND ITS RELATION TO CLINICAL IMPROVEMENT*

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Every psychoanalyst who thinks about his results soon begins to wonder and speculate upon the factors which bring about an easy cure in some cases, a slow one in others, and finally, in some, little or no improvement after many hours of work. The goal of the treatment, or, in other words, what should make the patient well, was defined by Freud as the making conscious of the unconscious—removal of infantile amnesia—or the overcoming of the resistance.

These are "telegrammatic" descriptions of what takes place technically in analysis. To understand what actually makes a neurotic person "well," that is, to achieve a reasonably continuous sense of well being, combined with social efficiency, we should study further what contributes to giving the average non-neurotic human a sense of well being and a reasonable degree of social efficiency.

There is a type of case which can achieve this through one or several gratifying libidinal attachments. True, these may be unconstructive attachments such as indolent or socially useless companions, series of attachments such as indolent or socially useless companions, series of amorous adventures, dilletantish hobbies rather than capabilities used in constructive activity. Or the patient may have difficulty in accepting responsibility and social usefulness but may enjoy the therapeutic relationship because of its gratification of dependency needs. If he can endure frustration, his libidinal attachments can be redirected.

However, there is another type of case in which the libidinal attachments are all joyless, and even after long periods of treatment, such a patient will still insist that no one or nothing gives him any sense of pleasure. As one patient put it, "I never knew how to live until I came into psychoanalytic treatment. But having learned what I might enjoy, I can't develop any feeling for it."

Michael Balint[1] says, apropos of this:

* Presented at a Staff Seminar of The Menninger Foundation, Topeka, Kansas March 13, 1946.

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"There are people who cannot give up demanding ever fresh compensation from the world for all the wrong ever done them, who know, indeed, that such behaviour is obsessional, and at the present time quite unreal—simply a transference, but nevertheless, cannot give it up, who want only to be loved and are not able to give love. On a few occasions, though not often, I have come to this point with patients, and have not been able to bring them further. These isolated cases, which, incidentally, showed considerable improvement, but which I was not able to cure, forced me to recognize the limits of my therapeutic powers. With my present technique, I can cure only such people as in the course of the analytic work can acquire the ability to attempt to begin to love anew. How these others are to be helped, I do not at present see. But I do not believe that we need let ourselves be defeated by the constitutional factors. Ferenczi used always to say that as long as a patient is willing to continue treatment, a way must be found to help him."

Help to the Ego

Freud[2], in his article on "Analysis Terminable and Interminable" says, "No doubt it is desirable to shorten analytic treatment, but we shall achieve our therapeutic purpose only when we can give a greater measure of help to the ego." Now the ego's great function is that of synthesis—of reorganizing its impulses and integrating them into the demands of reality. It can do its best work when comfortable and in a state of well being which comes about through love. It can accept the id impulses and unite them with reality demands in the most harmonious way.

If we study the psychoanalytic writing for the past twenty-five years, which is bound to reveal the therapeutic attitude of analysts, we see clearly a division (not too sharp, to be sure, but nevertheless there) in the attitude toward therapy. This attitude has had definite bearing on what Freud refers to as giving "a greater measure of help to the ego." Some emphasize, as Balint points out, "structural considerations", while others, notably Ferenczi and his followers, have given more emphasis to the "loving object relations."

DeForest[3] has stated this more pointedly as follows:

"An emotional relationship between analyst and patient must be allowed to form and must be constantly maintained. This is first initiated by relieving the patient's anxiety by encouraging discussion of the analyst, discussion of the patient's most patent characteristics, and discussion of their mutual relation; and it is continued by maintaining a changing and highly charged situation between them, primarily by the use of dialogue rather than by the usual passive explanation and interpretations of the teacher-pupil relation. During this dialogue the analyst should, when the occasion arises, express his own natural feelings to the patient's response. This serves to draw out his own natural feelings. Such dramatic interplay must in no way be artificially induced, nor should any element of insin-

cerity or inappropriateness enter into it. It must arise spontaneously and naturally.

"In continuing the drama, all is grist that comes to the mill, such as the analyst's eliciting criticism of his own personality, the attitude of friendly nearness to the patient, which makes unnecessary such artificial precautions as distance from the analytical couch or the furniture placed between analyst and patient, and the allowance of such freedom as the acceptance of tokens of the patient's esteem and affection, meeting of the analyst and the patient outside of the clinical hour. The more natural and fearless the relationship, the more helpful it is to the patient. All that creates the atmosphere of parent and child being intimately together helps to maintain the dynamic relation that Ferenczi considered necessary."

Later in her article, when she considers objections to Ferenczi's technique, DeForest says,

"To use the counter-transference as a technical tool, as one uses dreams, transference, association of ideas, and the behaviour of the patient, seems to many analysts exceedingly dangerous. Much of this anxiety has to do with the analyst's fear of his own impulses, his intuitional weakness, and his lack of self-knowledge. In so far as this is true, it points to the need for further and deeper analysis for the analyst, so that he may strictly and thoroughly know himself and his limitations. But in addition to this, there is often among analysts a preference for the teacher-pupil relation, a didactic and distant attitude toward the patient, rather than the tender, parental attitude. The teacher relation always allows the analyst to keep himself apart from the patient, to divulge just enough of his own personality to control the patient's confidence in him, to remain strong and self-assured in the eyes of himself and his patient, and to give help to the patient as a beneficial gift. The basis of this kind of treatment seems to be anxiety as evidenced in the patient's awe of the analyst. The patient learns because he must, and the hypnotic tie that binds him to the analyst may in the end be more unbreakable than the tie of tender devotion.

"Certainly, this dynamic type of analysis is more dangerous in unskilled hands than is the more intellectual and didactic type. The analyst, like the patient, tends to seek refuge in mental concepts and to function therapeutically on a mental level. They do this as a protection, for they fear to participate in an emotional drama. Undoubtedly, they thereby obtain results. But they could not approach more closely the kernel of the neurosis than by using the emotional language of the unconscious, if they attempted to work on its own dramatic level. Would they not be more likely to eradicate the neurosis and then to assist in the maturing of the individual if they dealt with him on an instinctive and a feeling basis?"

Such technique as DeForest suggests would surely promise to give what Freud suggested as a measure of help to the ego and yet Freud alluded to Ferenczi's experiments in active techniques as having been carried out "alas, in vain." The passage of time and the added experience of the

analysts in various situations do not seem to indicate that Ferenczi's experiments were in vain.

Infancy

The observations of workers with infants have a bearing on the problem of enhancing the ego's power to function. Margaret Ribble[4] says, "His (the baby's) first sense of security, of pleasure satisfaction and success is closely linked with his mouth activity. Sucking usually reaches the maximum intensity about the fourth month of life, and, if it has been fully and agreeably exercised up to this time, begins to diminish spontaneously about this time when the baby begins to vocalize, to bite, and to grasp with its hands. Most important to the infant himself is the pleasure value of sucking. The mouth activity relieves the tension and establishes relationship with the mother in an important way. Thus the budding emotional and social feelings, as well as early feeling of self, are connected with oral activity. . . .

"But she (the mother) knows, and close chronological study of these progressive reactions indicates, that through the medium of the mother's person and the delicate assistance that she gives, elaborate functional associations are being built up in the baby's brain. Babies who do not have consistent mothering are definitely less well equipped and do not seem to understand in later life such simple matters as loving and being loved."

We see Ferenczi in 1920 appreciating the emotional need of the patient who has undergone infancy deprivations and trying to meet his need in the transference situation. Twenty years later, we see studies like those of Dr. Ribble, which substantiate the needs for sensuous oral relations with the mothers which enhance the sense of well being and facilitate introjection. Then, in the speeded up treatment necessitated by World War II, we see a chemical (the barbiturates) introduced intravenously to facilitate the synthetic functions of the ego. This seems to be accomplished by the increased sense of well being produced by the chemical action on the hypothalamus and the thalamus.

Chemical Help

Freed[5], in a yet unpublished paper dealing with the use of barbiturates in civilian neuroses, says,

"The primary affective change produced by the specific action of the barbiturates on the hypothalamus, and possibly on the thalamus, is usually that of euphoria. The frequent comment is 'I feel good.' This may be preceded by the discharge of other emotions such as hostility or guilt. These can be considered affective outbursts which are of therapeutic value

in releasing repressed emotions. The relatively constant background state of euphoria, however, is of particular interest to the author. It is used to facilitate the psychodynamic processes of introjection and identification. These are possibly the earliest forms of affective relation to another person, corresponding to the earliest cannibalistic and the narcissistic stage of the ego. The patient regresses to an early oral stage of the ego, and the analyst is incorporated as a good object, probably because of the pleasure-toned affective state."

Ego Depletion

To be helped to feel good in all possible ways is necessary because the various frustrations, dangers, and unsatisfied needs during combat weaken the ego structure. Grinker and Speigel[6] say, "The soldier's living conditions on the battlefield afford a minimum of instinctual gratification. Both dependent and libidinal needs must go begging, and the ego must endure the *strain* maintained by the unsatisfied needs. Repeated narrow escapes from injury or death mock the ego's attempt to feel invulnerable; undermining its confidence until it becomes convinced that the next time will be the last."

They offer a neurophysiological explanation for this syndrome of ego depletion:

"In the severe anxiety states the physiological processes in the diencephalon seem to persist as a continual neural excitation. The stimuli are no longer present but the reactions persist with violent exacerbations due to mild external stimuli; or sympathetic charges may break through spontaneously. It is as if the diencephalic waves of neural energy continued beating in close circuits of internuncial neurons maintaining excitation for weeks, or months. It has been shown experimentally that the hypothalamus acts as a condenser, discharging repeated bursts of excitation which influence the cerebral cortex long after the cessation of the original stimulus." Translating this into psychological terms, they state, "through the artificial intervention of the drug the intensity of the reaction has been diminished; the pressure upon the ego is decreased. Accordingly, the potential ego span is widened. However, such an increase in the ego capacity remains potential, rather than actual, until the active intervention of the therapist is brought into play." Outlining the procedures of the therapist, they say, "Support and gratification of the patient's weakened and regressed ego by means of tenderness and attentive interest, and furthering of identification with the therapist's strength."

Here we see the utilization of a drug to enhance the object-relations which Balint spoke of in 1937. Do these things give any clue for either shorter or more effective psychotherapy, or both? It seems important that Grinker and Speigel[6], writing on war neuroses have attempted to postulate and correlate what happens physiologically with what happens psychologically. The tired business man or housewife may at the end of

the day have a similar ego depletion, which is cured by a nap or a temporary change of scenery, a cup of tea, or a cocktail. What does the oral (chemical) intake, the visceral intake, or the nap have to do with the hypothalamic, the thalamic, or the subcortical area? This is certainly something that we need to know more about. Perhaps we are on the eve of realizing the chemical aid to the solution of the neuroses which Freud, long ago, envisioned.

This chemical help, however, will doubtless have its limits of aid. Furthermore, it will, differing from insulin shock treatment, have to contribute to the sense of well being, the euphoria, in order to facilitate introjection of good objects either with or without regression.

Emotional Satisfaction

This still leaves much to be done with the transference and counter-transference phenomenon. And if we pursue this subject very far we come up against the popular prejudice against love and sensuousness. We are indebted to Dr. Karl Menninger[8] for bringing within sharper focus the therapeutic value of love, in his book entitled *Love Against Hate*. Nevertheless, the public still can see the emotional display only as weak or dangerously erotic in character. The men in service, who under pentothal cried, sought, and were not denied physical contact, were of the same sex as their psychiatrist and were sick men brought in in a crisis during patriotic service. Any widespread utilization of a technique of transference or counter-transference help which really met the needs of the patient, assuming him to realize its values and to utilize them, might be ever so helpful, but misunderstood and criticized by the public.

Therefore, to state a partial absurdity, but nevertheless, necessary to pose the problem, we could ask if it is necessary for psychoanalysts to stop their work of ego rehabilitation in order to educate the parents to give their children the optimum emotional satisfaction. If they have failed to do so, they should at least be understanding when the psychotherapist attempts to repair the results of this parental neglect at a later date in the child's life. Of course, such a procedure is not feasible, but such an idea seems to be helpful to show us where we stand. This leaves us to consider how much more resourceful we can be in making the psychic structure more pliable and receptive (with chemicals or hypnosis). Can we also be resourceful in bringing as much as possible into the patient's life, when he is receptive, to serve as pleasant memories neutralizing the traumatic ones of childhood? If recreational and occupational therapy help so many relatively easily, there must be a way to reach the seemingly completely uninspired. For some who have been indifferent to crafts, art may be

more sensuously satisfying. The beneficial effect of a satisfying love affair is well known. The removal from home to a sanitarium or other environment where more attractive scenery, a change in food, the kind administrations of new people, new faces, perhaps baths and massage to the skin may have their advantages even if the effect is temporary.

Too often this type of treatment was carried out for the neurotic without psychotherapy, and the phenomenon was comparable to the observation of Grinker and Speigel[6], as follows, "If a patient with a severely regressed anxiety state is given pentothal, and nothing more is done, he will sleep for a few hours, to awaken with no change in his clinical state; the potential increase in his ego capacity remains undeveloped, like an unplanted seed, and nothing happens. The activity of the therapist is vital to the success of the treatment. He must make contact between the partially restored ego and the anxiety situation."

In such a case "thalamic euphoria" had been created, but this was not enhanced by any psychotherapy which made contact between the partially restored ego and the anxiety situation, and no good introjections were made.

So, we seem to have in our analytic therapeutic movement forward, a philosophical progression which we see as follows: following Freud's concept of our psychic structure, there have been those who worked more distantly and intellectually to produce psychic structural alteration with emotional change a secondary consideration in their efforts, while others put emotional change first and the work of structural alteration was always in the service of producing emotional change.

Ribble and others who have attempted to isolate the nature and causes of these primary affects, have shown that the love of the mother and her appreciation of the need for sensual pleasure in initiating the affective tone of well being does a great deal, not only to favor introjection, but also to provide optimum brain (emotional-neural) conditions for establishing the rhythyms of these organs and organ systems under the control of the autonomic nervous system. She has not, however, attempted to isolate or describe what happens to the child neurologically or neurophysiologically. This much needed attempt was made by Grinker and Speigel.

Many have been dissatisfied with the analyst's preoccupation with the psychic super-structures of man without trying to link this with some part of the soma in a more tangible way. Following Grinker's lead, we would postulate that *the hypothalamus must act as a condenser not only for traumatic neural excitations brought about through a pleasurable nursing experience, but also as a condenser for any pleasant sensuous affectionate phenomena which follow the earlier nursing experience. These bombard the cortex with pleasant excitation eliciting pleasant rather than distressing*

phantasies. If their quantity and quality are maximum, the individual can stand great traumata before breaking down with a neurosis.

There is a pressing demand for the emotional needs of man to be made evident as a necessity—a necessity for psychic and psychosomatic health. We need to see more mention of the psychic needs of man in parallel with his somatic demands, and they must be expressed tangibly.

(1) Wheat → bread → stomach → digestion → assimilation → life (somatic)

(2) {Love, Affection, Chemicals, Hypnosis} → {Optimum sensuous satisfaction} → {Hypothalamus and Thalamus} → {sense of well being, enhancing introjection of good images and memories} → life (psychic)

When we try to be consistent about man's optimum sensuous needs, we shall have to combat our widespread sense of sin and guilt. But if we take emotional needs out of the class of luxuries and put them in the class of necessities for good neuro-physiological functioning, so that a sense of psychic well being and healthy somatic rhythms can occur with their resultant beneficial effect on human welfare and health, we shall be helping mankind and also making our therapeutic task easier. Our psychoanalytic-therapeutic philosophy seems to be moving in this direction.

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PSYCHOTHERAPY OF A PHOBIA IN A PILOT

By MILTON L. MILLER, M.D.*

Psychiatrists in military service, if in a position to do psychotherapy, had to apply dynamic methods in as brief time as possible. The following case report is of some interest because it represents the resolution of a phobia that had its inception in combat; with treatment it cleared up in two weeks. It was possible, at the time this patient was treated, to see him an hour a day during the brief period of treatment.

A B-25 pilot whom we shall call Arthur was admitted to a convalescent center with symptoms of anxiety, constant fidgeting and inability to relax. He was a tall youth, quite intelligent. He spoke rapidly, moved about in his chair uneasily, and looked around him a good deal as if looking for an exit. He tried to minimize his complaints, but admitted a disturbing phobia which began to develop after about thirty missions. He felt very uneasy when the seat in his plane would not move back, one day, and he was afraid he could not get out if necessary. After forty missions he was sent to a rest camp and then he went back and finished his missions. In a large European city, on his way back, he got stuck in an elevator and became very panicky. Subsequently, on the boat, in his room below deck, he felt hemmed in and afraid. Back in the United States, he felt uncomfortable in automobiles and could not remain inside movie theatres. On his way to the convalescent hospital he suffered from his claustrophobia in the Pullman and had to keep reassuring himself he could get out. When his wife was with him, he always felt much better. He had never had any similar fears up to the time of the thirtieth mission.

He told the examining psychiatrist that on his fourth mission a room mate was shot down in front of him but he did not feel that this disturbed him too severely.

When he was a lad of thirteen, he said, his father was killed in an automobile accident. Their family consisted of four: one older sister, a brother near Arthur's age, in the army, and a younger sister. He could not recall any other incidents of his early life that might have anything to do with his present nervousness, and said he was not fearful when he was a youngster, although he did bite his nails.

Because of the persistence of his symptoms and his inability to recall anything disturbing, he was interviewed while under the influence of sodium pentothal. He talked mainly of raids from his base in Italy. On his first raid, pilots of two planes ahead of Arthur were shot down—Hal

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and Dick. When Hal's plane was hit, Dick was circling around him. Arthur slowed down as did the others, and was told by the tail gunner that Hal's plane hit the water and blew up. Dick was shot down by two Messerschmidts and landed on the water. Three months later the bombardier of one of these planes 'walked home' and said that Hal and Dick and some of the others were O.K. These events evidently had no effect on Arthur's symptoms, and therefore were not of key significance.

Onset of Phobia

Then he talked of another raid near Rome when the only three flak bursts in the sky hit the bombardier and nearly hit Arthur himself. Flak hit the armor in the seat instead of Arthur, who happened to be leaning over, and hit the navigator in the arm. Arthur said he put sulfa on the navigator's arm, and, while discussing this, he burst into tears.

"Why are you crying?" he was asked.

He jumped up angrily and exclaimed, "I'm not crying. I never cry. I only cried once in my life—when my father died. I don't like to see anybody else cry, either." Then he added, "I wonder why I feel so strongly about it. I suppose that I really was very much afraid overseas and never wanted anyone to know it. Actually, I flew two missions when I had severe pain. It turned out to be appendicitis—but I didn't say anything about it."

"Why not?"

"I guess to be sure they didn't think I was a sissy or afraid."

Then the patient talked of the death of another friend, Mack. This was really the event that set off his symptoms. On this raid, Mack was flying in the patient's place, since Arthur's tail gunner had accidentally shot the tail off Arthur's plane and he had to drop out of formation and eventually return home. As Arthur was trying to hold his own plane steady, although it was shaking badly, he was told by his gunner that Mack's plane was hit by enemy flak and that Mack and the co-pilot were struggling to bring the plane out of a long spiral. With a profound feeling of guilt he said he should have been in Mack's place or have shown him somehow how to avoid flak.

It was several missions after this, the patient said, that he found his seat jammed as he was taking off, and developed marked fear of missions. He couldn't find things in the plane, fumbled, and was confused. On the next mission he asked to be grounded because of fear, and because of a strong feeling that he must not endanger his crew.

By this time the effect of the sodium pentothal was almost entirely worn off and the patient, who had been lying down, was now asked to sit up. The material he had just talked about was reviewed with him,

especially Mack's death and the onset of the phobia. He began to talk about the things that happened to him the night before. The landlady where he was living with his wife, near the convalescent hospital, had asked him, "Are they teaching you to do things with your hands?" He resented that. He said, "I don't want people to think I'm crazy. But I can't go down in an elevator unless someone is with me. And if it is crowded or if I'm pushed to the back, I have to get off and walk down."

"What does the crowded elevator remind you of?"

"I suppose the fellows in the plane."

"Yes?"

"But I'm going to get over this, don't you think so?"

"Yes, I do."

On the next day, talking again about these things, he stressed his need to have his wife with him, in order to feel more secure. He said he had been an accountant and had been married just a few months before volunteering for combat crew. He then began to talk again about his father's death—how, at the age of fourteen, he had heard of his father's death in an automobile accident through the conversation of neighbors, but he had pretended not to hear, and had gone through a whole day without admitting to himself it was true. Everyone felt very badly. But his mother said little about it. She and the patient both worked in offices, and were good pals.

About his father, he said that he was indulgent but was frequently away on long trips. He recalled how his father showed him how to box and fish. But then he added that he thought his father drank too much and he blocked on discussing this. He talked about his mother and said he had never seen her cry except once when she suddenly burst into tears and couldn't stop. He said the older sister was married and away from home and the younger sister was spoiled, but he felt very close to his younger brother.

Abreaction of Traumatic Event

The next day, sodium pentothal was again administered and Arthur was told: "You are taking off from the base at ————. What's happening?"

"It's a wet day," he said. "A fellow is crashing. Pieces of him scattered for a mile!" Then he talked of Mack, again. On that raid, he repeated, his own gunner's gun got out of control and damaged the tail of the plane. Arthur was forced to turn and head for home, pursued by fighters, but he evaded them through clouds. He reached home. Later the group returned and said Mack had been shot down, and they seemed to question the motive for Arthur's return to the base. Arthur felt very guilty but for no legitimate reason. Mack had taken his place in formation. Arthur

said, if he had been there he would not have been flying in that exact spot and then he would not have been hurt, nor would Mack have been killed either.

He told again how the others described Mack's disaster to him. Mack went into a long spin after being hit over the target and along with his co-pilot was seen fighting the controls in the cockpit as he was going down.

During the deeper stage of the pentothal narcosis, Arthur cried and kept calling to Mack as though he were actually in Mack's place: "Give the right engine more throttle, push on the left rudder," and he made appropriate movements with his arms. He talked about Mack's wife and how on the night before Mack was shot down Mack had confided in him about his wife and how he had hoped to get back to her soon. Then Arthur was tearful again and said, "Those bastards will pay for it," as though he were talking to Mack personally and promising him that he would be avenged.

When Arthur became more completely awake, this material which was so full of emotion was reviewed with him. He said, "When I heard about Mack I couldn't sleep. After that I dreamed the same dream a lot—I could see Mack struggling in his seat on the plane, going down. I think, now, that my own seat phobia is connected with Mack's death. It all centers around Mack."

The following explanation was then given to him: He had identified himself with Mack, and that was why he was afraid of the seat that jammed and he made this identification with Mack because of the guilt he felt about Mack's death. But actually there was no reason to feel guilty. He had to return to the base from that mission because of the tail of his plane being damaged and it was just pure accident that Mack had taken his place in the formation.

Improvement in Symptoms

The next day Arthur said he felt better and that now he could ride on elevators even if they were crowded. He went to a movie the night before, 'Gung Ho', a war picture, and he had no difficulty even though it showed two men with claustrophobia in a submarine.

Once more all the circumstances of Mack's death were reviewed with him. He admitted that he often had dreamed of himself in Mack's position, struggling in a plane without controls, going down in a spiral. For months, he said, he felt very tense, bit his nails, etc. These dreams persisted until a few days after he reached home.

It was pointed out to him, again, how he identified himself with Mack out of strong guilt feelings but he had no real basis for this guilt.

"I felt certain I'd get it next, in just the same way."

"Was there anything more about Mack? Anything in your relationship with Mack that you've tried to forget?"

Arthur then talked of Mack's first mission as a first pilot. Arthur was co-pilot on this 'milk run'. Near the target, in a cloud, Mack pulled out of formation to the left and above. Arthur said he felt that he, himself, would have continued to fly in formation because usually he can see enough to see where the other planes are. Finally Mack got in formation on the way home. At that point, Arthur asked to take over the plane and did so.

"You had some criticism of Mack?"

"On that mission Mack was 'big dog'"—Then Arthur caught himself, and laughed. He explained that 'big dog' is the term for first pilot. "I wonder why I laughed". . ."I guess I always thought Mack considered himself a big shot."

"Then you did have some critical feelings about Mack?"

With a very sad expression on his face, Arthur ignored the question and again talked of Mack's death.

It was pointed out to him that he had a critical feeling, but that it was followed immediately by guilt feelings, in which Arthur identified himself with his dead comrade.

Arthur then brightened up and talked about how, after his appendectomy, he went swimming in shallow water near their base, while Mack was out on a raft swimming and diving. He said, "Mack was a good swimmer but so am I". . ."Because of my operation, Mack was a dozen missions ahead of me, and in order to catch up with him I offered myself for every possible mission in spite of the flight surgeon's warning that I was overdoing it. I used to go to the board that recorded the number of missions of each man, to see how many missions they had, but I always looked particularly at Mack's score. Mack's name came right after mine, alphabetically."

Arthur reminisced again about the night before Mack's death. He and Mack had gone to a movie. Mack said, "I'll soon be on my way home. Only seven more missions." Arthur felt very envious—Mack was ahead of him.

Arthur completed several missions after Mack's death and was very much afraid on these. He was offered the position of first pilot and leader of the element, but he told the commanding officer he just couldn't take it.

"Do you see the connection?" the therapist asked.

"I do now. But then all I knew was that I'd sure get hit—I see now that it was because of these feelings."

"You couldn't accept the position you wanted, because of your strong competitive feelings and your guilt feeling about Mack, and all you real-

ized,consciously was that you were afraid you'd be killed just as Mack was, especially if you did become first pilot."

"Yes. You know, another time, at a different base, I was offered the position of first pilot again and couldn't accept it. Then that day when the seat jammed I began to feel so afraid."

The next day, when seen again, Arthur said he felt so much better, he could now ride in elevators, go to movies, and even sit in the balcony without having to be on the aisle. He said he felt a little tired and depressed last night, partly because he had wanted to go to the movies at the hospital but his wife had invited guests and they went in to town. Before going to bed he thought of many things: about Mack's death which he did not dwell upon very long; and about a mission after Mack's death.

On this mission, he was flying with the Colonel as co-pilot and as they came over the target in the second element the flak ceased and the Colonel told them it would be easy. They saw P-38's engaging some fighters and as they passed the target the flak resumed.

"You now seem to be able to think about missions which were easy and successful and this is a good sign."

Arthur smiled, and began to talk about how he had tried to handle the problem of flying before he came to the hospital. He had planned to try to get a position as a training instructor in a training field where he could fly alone and master the plane.

"Perhaps this recalling the easy mission with the Colonel also is a reflection of your feeling that you are getting some help with this problem here," he was told.

Childhood Predisposition

Then Arthur began to talk again about his father's death and how he became his mother's confidant, and tried to help the other children get an education. He became an accountant because the job was available, but disliked it.

He said that the night they learned of his father's death he simply pushed the idea out of his mind and went to sleep and wouldn't believe it. When he finally learned definitely from his mother that his father was dead, he said, "That means I can't go to college, doesn't it?"

After confessing this, he asked the therapist if that meant he was extremely selfish. Reassurance was given to him. He then said his father was a salesman and never went to college, but Arthur wanted to go to college and become a professional man.

"You wanted to exceed your father's achievements. You really were competitive toward him. And at the same time you had this strong affection for him."

"Yes, I see that."

"After Mack's death, you had similar feelings. You were sensitive to just such an accident."

He thought about this for a moment, and then he told how his father used to help him when he was home. Occasionally he would get up at 4:30 on a Sunday and help Arthur deliver his papers and they would have breakfast together somewhere. He was indulgent; for instance, he gave Arthur an automobile. "Of course, I think I was spoiled, to some degree," Arthur admitted. "But I wanted to be independent. I liked to do things on my own. As a pilot going overseas I felt far behind the others because I had had less hours of instruction and I constantly tried to make it up. I was aggressive about it and tried hard."

"Try out those situations you have been so afraid of. You know the emotional background of them now. There's no reason why you should not be rid of these fears now and get well."

Transference Interpreted

The next day Arthur came in and said he had been quite angry and even felt like throwing a book out of the window, but restrained himself. He said he had wanted to go to town to buy clothes, instead of coming to see the psychiatrist. He also said that last night he was discussing the doctors with the other patients, and he told them that at first he wasn't sure he liked the therapist, but he did at the second interview.

"Evidently you are protesting about something—wanting to be independent. Perhaps you feel dominated in this therapeutic situation?"

"Overseas in a similar situation I blew my top, and really did throw a book. But most often I'd walk outside until I cooled off". . . ."Once a friend of mine called me a sissy. And once when I was learning night flying the instructor put me on my own very early and said, 'Don't be a sissy about it.' That made me very angry. I went on my own, and made bumpy landings—but I kept at it. In primary training I was very sore at an instructor who nagged me—he never directly said I was a sissy, but I interpreted it that way. After I got angry, the instructor was pleased, and we were good friends."

"You must feel that in coming for these treatments you're too submissive. You're telling me about how you disliked other similar situations and protested about them. Do you think that goes back to any relationship with your father?"

"That reminds me. When I was eight years old, my father used to teach me to box, and once he accidently hit me on the nose and it bled. I got furious and hit him back. He always used to say when he was teaching me how to box or do things, 'Now don't be a sissy'."

"You were urged by your father to box and do masculine things, for a young boy, perhaps beyond your capacity. Sometimes perhaps you would have preferred to dodge such situations and be protected by your father. It seemed a kind of weakness to you, to want his protection. Now it's the same way in the therapeutic situation: you feel it is a kind of weakness to come to the psychiatrist and you protest and want to show you're as much a man as anyone else around."

Arthur then mentioned an episode when he was ten or eleven, when a boy dared him to jump from the roof of a garage to a chicken shed. He was afraid but tried to do it, stumbled and fell, knocking out his wind. Then he returned to the subject of how his father always tried to make him "a man." He taught him to drive very early, when he was eleven. Before that, he used to sit on his father's lap and steer the car. His father once wrote him in a letter, "Always try to be a man," and Arthur never forgot that.

Then Arthur recalled how his father had an automobile accident when Arthur was about eleven, and was hit in the chest with a steering wheel. He was in the hospital for some time and after that was never quite the same; he would become very confused at times, while driving.

It was now possible to discuss with Arthur the entire trend of his fears about accidents related to getting stuck in the seat of a plane while flying it, or automobile accidents, and the other facets of his phobia. He realized for the first time that it was natural for him to have mixed feelings toward his father, particularly since his father had definite weaknesses (later Arthur had learned that he drank very heavily; and now for the first time Arthur felt able to talk about these positive and negative feelings in regard to his father and to other men, such as Mack).

The next day Arthur came in full of thoughts and questions about resuming his flying duties. He wanted to go back to duty but not to return to overseas combat 'right away'. "I don't know whether I will feel shaky when I get into a plane again, but I don't think so."

He was reassured that he was now ready for flying duty and that he knew now what his shakiness in the plane meant: it was his reaction to Mack's death, his identification with Mack, and his feeling of guilt—which really was not necessary. The extension of this fear to other situations, such as elevators, movies, etc. was reviewed with him. He was told not to be discouraged if he felt some initial uneasiness about flying. With his knowledge of the cause of it, he would be able to handle it.

"I have no more fear at all of elevators or movies," he said. "My wife has noticed this improvement, and also I'm much less irritable, and I'm anxious to return to duty."

"You are ready to do so, and should be leaving this week."

Summary

This report shows the way in which psychotherapy helped a patient who was of normal personality prior to military service, and who did not undergo unusual personal combat stress for an aircrew member, but whose emotionally vulnerable spot was struck by witnessing the catastrophe of his close friend, which paralleled his father's accident. His relation to the pilot who was killed resembled in detail his conflictful feelings about his own father and stimulated feelings hitherto repressed and held back from consciousness. The bringing to light of these emotions, and his realization of how they fitted in with his phobia about automobiles, airplanes and closed-in places, relieved most of his anxiety symptoms and restored his confidence.

The handling of the transference situation played an important part in the dynamics of this patient's improvement. In essence it consisted of the following steps: (1) diminution of guilt feelings by initial reassurance so that the guilt feeling would not interfere with revealing the conflict material. This was a permissive role of the therapist, a relaxing of the relationship of military discipline for the sake of a therapeutic relationship. (2) The therapist, by interpretation and manner, and tone of voice, as the treatment went on, replaced a fearful father figure in the emotional setting of the treatment by a more tolerant and understanding one, and then through the release of anxiety and the abreaction, the patient's repressed conflict material became more accessible—the patient knew he would not be criticised. (3) The attempt of the patient's ego to handle the repressed material consciously instead of constructing defense mechanisms (spread of the phobia), was actively encouraged by the therapist by a cooperative discussion of the fear-provoking material, with the demonstration of the patient's real ability to handle it. Toward the end, the patient really referred to the treatment situation when he discussed the incident in which the Colonel whom he liked told him that they were going on an easy mission, and the Colonel's statement proved to be correct. At this stage the patient indicated that he felt able to begin to master his fear.

N.B. Follow-up study on this patient after he returned to duty was not possible.

AMNESIA WITH SPONTANEOUS RECOVERY: A CASE REPORT*

By CAPT. K. R. EISSLER, M.C. and CAPT. JACOB SIEGEL, M.C.†

A seventeen and one-half year old trainee was admitted to the Regional Hospital a few days after his arrival at the Infantry Replacement Training Center. He reported having been perfectly well until eleven days prior to admission when he developed a slight, persistent cough which became gradually worse. Due to the excessive coughing he felt soreness in his chest. A fever was detected, allegedly, at which time the patient was sent to the hospital.

Physical examination revealed positive findings of a congested nasal mucosa and moderately injected pharynx. The patient spoke hoarsely, in a whisper, and on auscultation of the lungs moist, coarse rales were heard on inspiration, posteriorly, at the bases. The diagnosis of laryngo-tracheo-bronchitis was made and the patient was put on penicillin therapy, 30,000 units every three hours, besides the usual analgesics, nose drops and cough medicine. On the third day of the penicillin therapy and the fifth day of hospitalization, when he returned from the x-ray department shortly after lunch he dozed off in bed and slept for one and one-half hours. He awoke about 2:30 P.M. and found that he had no idea of who he was or where he was. He was amnesic for remote and recent events.

Physical examination at that time was negative. He had had 450,000 units of penicillin. At no time, from admission into the hospital until discharge, did the patient have any fever.

When the patient became aware of his amnesia, he became greatly upset, fearful and tearful. He was reassured by his physician and told that he would soon recover. After two and one-half days no change had occurred. He became angry and accused the medical officer of having lied to him. He was advised to read all the letters he had received from home to help him recover his memory. Shortly afterwards, he called the physician and announced with great joy that he had regained his full memory. Examination confirmed the fact. He knew his name and serial number, details of his hospitalization and could explain all the names mentioned in the letters.

The following report is based on the material obtained from one psychiatric interview. Though no new aspect of amnesia could be obtained in

* This paper is a shortened form of the original report which was read at the Staff Meeting of the Medical Service at ASF Regional Hospital, Ft. McClellan, Ala., on 21 December 1945.

† ASF Regional Hospital, Fort McClellan, Alabama.

the study of this patient, there was some confirmation of present ideas on the origin and recovery of amnesia which makes it worth while to present the case history.

The term amnesia is used for conditions of variegated psychopathology. It is permissible to say that everybody is amnesic to a certain degree. Not only are our memory functions not prepared to preserve all details of conscious experience in such a way as to keep them accessible to our demand, but very pertinent and significant experiences, perhaps even the most significant experiences, are repressed and cannot be remembered unless special conditions are introduced. Hypnosis or drug narcosis might help in the recovery of some such memories. It is well known that in dreams long forgotten contents may reappear. However, the person who cannot remember such important memories is not aware at all of being amnesic. On the contrary, when attention is called to the probable loss of recollection of those experiences, the subject is usually incredulous. No fear or panic is expressed when the subject finally becomes convinced that he cannot remember an important part of his past life experience.

Then there are clinical instances in which patients who are mainly hysterical, forget experiences which were highly charged emotionally. Again, the subject does not notice the amnesia and is not interested in its recovery. Such amnesias are crude self-defenses against unpleasant impressions and usually can be recovered easily.

The case under discussion was a different type of amnesia. The patient lost the memory of pertinent data pertaining to the very basis of his existence, such as name, age, and his general background. Such data are indispensable to the ego's struggle for self-preservation and discrimination. Whereas in the above mentioned types of amnesia, especially in the hysterical person, a motive can be found specifically for each amnesic content, no such motives can be ascertained for the specific contents of a total amnesia. There was no special motivation for the loss of memory of the patient's name as against that of the names of his siblings. It was a total reaction, a blocking of all the memory contents accumulated up to a certain point in the patient's biography. The temporary loss of one of the most important weapons in man's struggle for self-preservation, survival, achievement of satisfaction and happiness must have been enforced by a conflict pertaining to the total personal configuration.

The patient could remember after recovery that before falling asleep he was preoccupied by thoughts of his girl friend. He had written to her from the reception center asking her to accept his ring. During his hospitalization, one day prior to the onset of the amnesia, he had received a letter containing her negative reply, telling him that she preferred to postpone such decision until a later date. There was no indication of

hostility or unfaithfulness on her side expressed in the letter, but rather the natural cautiousness of the female when abruptly confronted with a situation which to all indications, appears uncertain. The patient, however, felt duped. He had courted the girl for over a year and he had vague ideas about a rival who might have deprived him of his girl's love during the time of his short absence. He felt compelled to doubt the sincerity of the girl's previous love for him. He was certain that he had had no dream during the short sleep preceding the amnesia and he claimed that from the first moment of awakening the state of amnesia was present.

He further could not explain his sudden proposal to the girl after he reached the reception center. He had been her supervisor in a factory and for the first two months he did not get along at all with her. She had a sharp tongue and he tried to embarrass her by assigning her to unpleasant jobs. After two months he suggested that they "bury the hatchet" and asked her out for lunch. It was the first time that he had asked a girl out. From his description, the fact that she wore a uniform seemed to have been of some pertinence. Later, another young man who worked in that group tried to get closer to the patient's girl, but he was rejected by her. The patient took her out to dances and introduced her to his parents. She was well received by his family and his father used to tease him in a friendly, joking way. His father made remarks about marriage but the patient never entertained that idea seriously, feeling that he was too young.

Now he claimed that since being in the Army, he had risen to the situation, had matured, and had concluded that it would be the right thing to do. In view of the short duration of his military service, this can easily be recognized as a rationalization. Something must have seriously troubled him after he left home. Like so many others he tried to establish a situation of emotional security. It certainly was not love which drove him towards an attempt at making his relationship with her a permanent one. He claimed to feel at ease in the new group he had recently joined. He had won $230 in a dice game on his way to camp. He returned thirty dollars to one loser out of pity for the soldier. He wanted to buy the ring with this money and the fifty dollars he had taken with him from home. (Did he want to redeem his aggression against the male group by marriage?) Before he left he told the girl she need not stay at home during his absence, as he did not mind her going out, a privilege he demanded for himself also.

An explanation of the psychodynamic background of the patient's amnesia might have been possible if more had been known about his motivation for volunteering for the Army. He had not yet reached his 18th birthday and could have stayed at home. The patient was unable to give any pertinent reason for his joining the Army. He came from a Catholic family and was reared in a large middle-western city. He left

school after the tenth grade. He worked with his father for one year and suffered a minor accident, which resulted, as he claimed, in a pain in his leg, which prevented him from continuing his truck-driving. He got a job in a defense factory, where he met his girl. In July of the previous year he had an appendectomy and developed a "nervous breakdown" during hospitalization. He was restless, could not sleep and "saw people walking around where no people were," but this condition subsided within one week and he was discharged. He returned to his former work, but became unemployed four months later because the factory closed. Then he enlisted in the Army. The return of an older brother from overseas was impending. There were three older and three younger siblings. One younger brother had died at the age of eight months when the patient was twelve years old. For seven years he was the youngest and when the brother younger than he was born, his parents teased the patient by saying that he would now lose all the privileges he had enjoyed up to then. He received the newly born brother with misgivings but managed to retain his privileged position even after the subsequent birth of other siblings. "I am father's and mother's pet," he boastfully admitted. His next younger brother eventually became his best friend. When his mother became pregnant with the child who died eight months after birth, the patient was bedridden with pneumonia between Christmas and New Year's, two weeks before the delivery of the brother. It is noteworthy that the patient's amnesia occurred shortly before Christmas. It was a family custom that the father moved out of the parental bedroom and slept in the sick child's bed, whereas the child had the privilege of sharing the mother's bed during the time of sickness.

The patient was a voluble person and emotionally alive; he appeared somewhat driven by his affects as if he were in a perpetual hurry. Hence he presented more material than can usually be elicited in one interview. The proximate psychogenic background of his amnesia is fairly recognizable, especially if the sentence in his mother's letter which brought back his memory is considered. She wrote in response to his complaints about Army food: "I wish I could be with you and cook for you."

The immediate precipitating factor was his girl's rejection. The patient was a competitive, ambitious personality as encountered sometimes in the "youngest" sibling. He was accustomed to victory and this resulted probably in a persistent expectation that impulsive desires would be carried to gratification. The previous short psychotic episode following the appendectomy might, superficially viewed, be considered an expression of his inability to accept even temporary defeat and his propensity to develop marked anxiety when facing a reality which does not bow to his wishes. Moreover, sickness, especially respiratory, must have acquired a meaning to him in view of the history of the pneumonia at the age of

twelve. To be sick meant to push his father away from his mother and to gain entrance to her bedroom and this must have been a very critical situation for a youngster whose mother was pregnant with a child who was to die eight months later. Significantly, at the time of the interview, he was under the wrong impression that he was sick with pneumonia before developing the amnesia. Actually, as mentioned above, his diagnosis was laryngo-tracheo-bronchitis. The patient was aware of his feelings of sibling-rivalry and with a modicum of construction it can be assumed that the patient harbored aggressive impulses against the new, yet unborn rival, and established the well-known magic connection between that impulse and the subsequent elimination of the younger sibling.

A fair outline of the psychodynamic background of his state of mind when falling asleep shortly before the onset of amnesia might run as follows: "I suffer from a sickness which once got me close to Mother when I was in danger of losing her love. A rival died shortly after that time. My girl does not want me because a rival robbed me of her love for me." A total amnesia may set in, as N. Lionel Blitzsten* has repeatedly demonstrated, when an aggressive and destructive impulse is on the verge of breaking through, an impulse which is incompatible with the person's ethical standards. A total amnesia may be compared to the instinctive behavior of some animals which stop all movements and feign death when exposed to danger. Thus they try to escape annihilation by faking death in view of a vastly stronger aggressor. In a total amnesia, the ego acts as if a part of it had died. The entire past is blotted out. The intended aggressive impulse is blocked and with it the total life experience. How far back the amnesia may extend probably depends on the intensity and extent of the shunned aggressive impulse.

When this patient returned to his ward, he did not return like the conquering hero of childhood times who defeated father and was received by mother's affection; he returned to a ward where many other patients were treated and no special attention was paid to him. He was deserted by the entire world including his girl and his mother and he was left without any affection. Had it been a conflict restricted to his relationship to the girl he might have awakened with an amnesia for his attempts at marrying her or he might have solved the conflict with an aggressive dream.

It is interesting that in his attempts at self-treatment, the patient established a situation which has been recommended by Blitzsten in the treatment of amnesia, namely, an approach toward the reestablishment of the original pathogenic situation. It is significant that the patient regained full power of his memory when he read in his mother's letter that she would like to be with him and fulfill her maternal duties. This sentence

* Weekly Seminar on Psychoanalytic Psychiatry, Cook County Hospital, Chicago, Ill. 1940–1944.

contains the traumatic situation and its "remedy", in one. It refers to the state of separation and abandonment and simultaneously proffers consolation. This two-fold aspect pointing to the trauma and its opposite ("I am deserted but after all, somebody loves me,") appears to have lent that passage its singular power to undo the amnesia.

Speaking generally, there are two different kinds of memory content. One kind is practically always accessible to us; the other kind might come or go regardless of a person's effort at control. The first recollection of dreams, for example, after the dream night falls into the second category. In the act of recalling a dream for the first time, the ego usually is passive; it is overwhelmed by something that suddenly and unexpectedly appears on the stage of conscious ideation. A careful check of the situation in which the recollection of the dream occurred reveals a meaningful connection between some factors in that situation and the dream, including its dynamic background. Likewise, the reappearance of the patient's lost memory contents occurred spontaneously, suddenly and in block, not piece-meal. In spite of the patient's preceding effort, not a single content had found its way into his consciousness. He had to wait until a propitious constellation accidentally resulted in such a distribution of forces as to remove the barrier which blocked part of his life experience. This was possible as soon as reality offered a content which was related to the complex enforcing the amnesia and which was strong enough to re-establish a connection with the blocked and temporarily repressed contents in his unconscious. Freud has described a similar dynamism in the sudden recollection of a forgotten word.

Another point of interest is the patient's panic and terror caused by the amnesia. If one of the authors is not mistaken, the majority of amnesic patients previously interviewed did not show the degree of perturbation which this patient did. Indeed, the other cases were frightened also but their fright was somewhat repressed and not clinically manifested, whereas, in this patient the loss of memory might have constituted a greater shock to the ego than the impact of the internal conflict. This would be an important factor in the process of spontaneous recovery.

It is difficult and hardly possible with present means of investigation to speculate on the extent to which penicillin might have had its bearing on the amnesic episode. How far his infectious disorder and the treatment involved might have channelized the psychopathology into the specific clinical form of an amnesia, cannot be decided. At the time of the interview the patient urgently demanded to be sent to duty. He hoped to get a Christmas furlough. He desired to go home as he was certain that, were he there personally, he could induce his girl to accept his ring. Could he have been struggling with an impulse to go AWOL before he fell asleep?

SOME PROBLEMS IN NARCOLEPSY: WITH A CASE REPORT

By NATHAN ROTH, M.D.

Many general reviews[1–13] have appeared in the literature regarding the syndrome of narcolepsy, which is characterized by periods of diurnal sleep and of flaccid paralysis, the latter usually induced by emotional experiences. Disputes as to the nature of the disorder exist and prompt the present case report.

The relationship of narcolepsy to the convulsive disorders has been a matter of controversy for many years. When Gélineau[14] coined the term "narcolepsy" for this syndrome, he "asserted that he had described 'a new species of neurosis' that had nothing to do with epilepsy whatsoever." "Jelliffe was among the earliest . . . to point out that narcolepsy is not a 'disease' per se or a morbus *sui generis*, as Gélineau called it, but a symptom that may occur in a variety of conditions"[7].

Notkin and Jelliffe[7] state that Adie, Redlich, Curschmann and Prange and a few others "have disputed the close relationship to the epilepsies, pointing out that epileptic attacks occur spontaneously while narcoleptic attacks are emotionally determined. This is an erroneous conception; one has only to consider the common 'affect epilepsy' to dispel the notion that epileptic attacks are always spontaneous (Notkin)." Most important are the cases, referred to by these authors, having "a mixture of both narcoleptic and epileptic attacks or with a transition of one form of attacks into the other." Notkin and Jelliffe suggest that the narcolepsies are closely related to the epilepsies. Wilson[6] believed that the narcolepsies resemble the epilepsies in the "periodical recurrence of attack, abrupt onset with or without aura, loss or diminution of consciousness, relatively brief duration," etc. Yet Adie[3] considered narcolepsy to be an idiopathic disease and insisted that it was distinct from epilepsy. According to him, "Epilepsy is hardly the best label for patients with sleep attacks and cataplexy only. No patient with these symptoms has ever become epileptic in the ordinary sense, although some of them have been narcoleptic for twenty, thirty, in one case forty years."

Like Adie, Daniels[1] felt that "in view of its distinctive clinical manifestations and its apparently less serious nature, . . . , it would seem advisable to regard narcolepsy, for the time being at least, as something distinct from epilepsy. That certain states which seem to represent a transition between the two conditions are occasionally encountered no one can deny, but, as Redlich remarked, many diseases have maintained their independence in spite of such transitions. So long as the essential nature of the two conditions remains in the realm of hypothesis, it is better to rely on the results of clinical observation."

In further reference to the relationship between narcolepsy and the epilepsies, Notkin and Jelliffe[7] said, "This relationship may be resolved satisfactorily when more patients have been completely analyzed at the physicochemical, sensorimotor and symbolic levels. Research should be carried

out at all three levels of the integrated individual." This injunction can now be pursued more thoroughly with the modern emphasis on understanding the individual as a whole, with the assignment of appropriate significance to emotional disturbances in the etiology of disease, and with the advent of the electroencephalograph.

Gibbs and Gibbs[15] state that the electroencephalographic "sleep records of narcoleptics are like those of normals except that the decline to a deep level of sleep is more rapid." According to Murphy[5], "The electroencephalographic findings in these cases show little evidence of pathological cerebral dysrhythmia," and "Narcoleptic sleep is indistinguishable in appearance and electroencephalographically from normal sleep." Dynes and Finley[16] found that, "The electroencephalographic technic . . . yields evidence of dissimilarity between narcolepsy and epilepsy. There is nothing in the character of the electrical discharges from the brain of the narcoleptic patient which would link them with the abnormal electrical discharges from the brain of the epileptic patient. . . . In 16 cases of narcolepsy the brain potentials during the narcoleptic attacks were found to resemble those of physiologic sleep. . . . Patterns consistent with epilepsy were not observed in any of these patients, and none of the patterns observed during the narcoleptic attacks could be induced or exaggerated by hyperventilation for a period of two minutes, in contradistinction to the reaction in epileptic patients. . . . In 17 of the 22 cases normal waking patterns occurred. In the remaining 5 cases abnormal waking patterns were present. . . . One might say that those patients showing normal waking electroencephalographic records fall into the 'idiopathic' group, while those showing abnormal waking records are more likely to fit into the 'symptomatic' group."

Of related interest is the report by Rushton[17] of two cases of sleep paralysis, in both of which the electroencephalogram was "essentially normal"; while these patients did not have diurnal sleep attacks, sleep paralysis is a common phenomenon in narcolepsy. Cutting[18] reports four cases of narcolepsy in which the electroencephalogram was normal in all. After reviewing the electroencephalographic and other evidence, Furtado and Valente[12] conclude that narcoleptic sleep is identical with physiologic sleep, and that the epilepsies and narcolepsies are independent entities, the latter conclusion not being invalidated, in their opinion, by the "rare cases in which both conditions appear in the same patient."

Janzen[19] is also of the opinion that the electroencephalographic record of narcoleptic sleep is that of normal sleep, and that narcoleptic patients show no electroencephalographic evidence of convulsive disorders. Cohn and Cruvant[20] reported ten cases afflicted with diurnal, uncontrollable sleep, in five of which "affective stimuli induced cataplectic muscular phenomena," and stated, "In this series of cases inconstant, but definite, abnormalities of the electroencephalogram were observed in the waking state. Moreover, these abnormalities were qualitatively similar to, but quantitatively less prominent than, the electroencephalographic changes commonly associated with the epilepsies. . . . The basic electroencephalograms, taken between intervals of 'sleep', showed no wave pattern characteristic of the narcoleptic syndrome. . . . The abnormal wave forms observed in the majority of the records were similar, in all essentials, to those obtained from

epileptic persons. . . . The 'epileptic' response to hyperventilation was noteworthy in case 9 and in case 10. . . . Since the electroencephalographic abnormalities observed during the interseizure phase of the hypnoleptic (narcoleptic) syndrome appear qualitatively similar to those associated with the epilepsies, it appears that Wilson's concept that the narcoleptic (hypnoleptic) syndrome is a member of the family of epilepsies is confirmed."

These authors did not observe in the electroencephalograms of their patients, the three per second, wave and spike forms typical of petit mal epilepsy. It is evident that there is no unanimity in the electroencephalographic findings in narcoleptic patients in the waking state, and that the electroencephalographic evidence has not, as yet, solved the problem of the relationship of the narcolepsies to the epilepsies.

Another problem which has provoked dissenting opinions is the significance of emotional factors in the pathogenesis of narcolepsy. In the majority of earlier reports the syndrome was thought to be of organic origin, although some cases were thought to be of psychopathologic nature.

Adie[2] said, "most of the cases are mistaken for epilepsy, some for hysteria; it is certainly distinct from both." He felt that, "True narcolepsy is a functional disorder of the nervous system, probably an undue fatigability of nerve cells, in individuals with a peculiar kind of nervous activity that allows excessive responses to emotional stimuli and favours the spread of inhibitions. . . . The pituitary body with the nucleus hypophyseus and adjacent vegetative centres in the floor of the 'tween-brain forms an endocrine-nervous system; . . . narcolepsy is primarily a disorder of this system." Subsequently he said[3], "Narcoleptics do not show hysterical traits more often than other groups in the community; their symptoms cannot be produced by suggestion, and they do not respond to any form of psychotherapeutic treatment."

According to Gill[10], "Such cases are organic, and not, as still described in some textbooks, hysterical. Symptoms produced by suggestion may be superadded, as they may in any organic disease, and may be removed by superficial psychotherapy. There is no case yet on record where the whole picture has been altered or improved materially by psychotherapy, even by deep analysis." Daniels[1] felt that, "One may reasonably doubt . . . that mental and emotional anomalies have any significance so far as the etiology of narcolepsy is concerned. . . ." Brock and Wiesel[21] pointed out "the resemblance of these organically conditioned states to those of hysteria." Murphy[5] concluded that, "Narcolepsy is a borderline syndrome common to cases of both functional and organic brain disease." Wilson[6] gave reasons for disposing of "the contention that in . . . narcoleptic cases any structural impairment, or any more or less permanent abnormal physiological state of the mechanisms concerned, is in existence."

Jelliffe[7] was of the opinion that those cases "in which a most careful examination fails to reveal any definite evidence of involvement of the central nervous system or of any other system of the organism . . . lend themselves . . . to psychodynamic interpretations, and such attacks may be looked on as an expression of psychologic regressive mechanisms." Missriegler[22] reported the case of a young man with attacks of sleep only, in whom "The gradual uncovering of . . . conflicts by psychoanalysis, not

without great resistance on the part of the patient, resulted finally in a complete cure of the narcolepsy and a marked improvement in personality development. . . ." Worster-Drought[23] said that in most cases which are not associated with organic disease, the attack "is initiated by a complex of psychical origin."

Finally, Langworthy and Betz[24] state that idiopathic narcolepsy is a "personality reaction to emotional issues, rather than an organic disease as has formerly been assumed. . . . The narcoleptic syndrome as a neurotic reaction seems similar in many respects to the hysterical reaction. . . . In our experience, these patients have proved responsive to psychotherapy which should provide a fundamental approach to their difficulty." The hitherto expressed opinions of the pathogenesis of the syndrome run the gamut from purely neuropathologic lesions to unalloyed psychogenesis.

The following case report is presented in illustration of the two disputed points outlined above, namely, the relationship of narcolepsy to the convulsive disorders, and the importance of emotional factors in the pathogenesis of narcolepsy.

Case Report

History: The patient was a 36 year old, single, white female, the eldest of five siblings, and the only one still living at home with her aged parents. In the family scene the father occupied a position in the background; for forty years, until his retirement, he had worked as a clerk, was quiet and timid, and seemed to have few interests other than his work and the daily newspapers. The mother was the dominant figure, setting the patterns of behavior for the children, firm in her convictions, and proud of the fact that there were distinguished persons in her family and that her only son was a professional man.

While pleased that her daughter had followed her example in many directions, she regretted that the patient had carried this compliance to extremes. The orderly manner in which the patient kept her dresser drawers was approved of, but her refusal to share soap or a comb with other members of the family was frowned upon. Her preference for the company of professional men was praised, but her requirements for a potential husband were considered too exacting. The mother was devoutly religious, the father had changed his religious affiliations to please the mother, and the patient found her "greatest comfort" in the church.

The patient had always been considered timid, bashful and inhibited. She was "not the type to get into difficulties" in school. All through high school "her trouble was that she would not talk up." Rather than remonstrate with other pupils who wished to copy her work, she would do their work for them. Although she liked to be with people, she had little to say

in a group, and had never had any intimate friends. She had "read books to bring out her personality."

After finishing high school at the age of 17, she attended a business school and then became a secretary. At the time of her examination she had held one position for 18 years, and had missed only three days of work. Despite this exemplary record, she received only a mediocre salary.

The patient had had measles, whooping cough and chicken pox in childhood; she had never been seriously ill, and there were no noteworthy injuries. At the age of 13, during her first menstrual period, she lost consciousness; she was alone at the time, and thinks she was unconscious for a few minutes. During her succeeding menstrual period, she again lost consciousness while in the presence of her father; during this attack there were no tonic or clonic motor phenomena, and no incontinence. There has been no recurrence of these seizures.

She had observed that she could fall asleep more easily than other people during the day time, but she did not attach particular significance to this fact, until her brother drew it to her attention. At work she often had a great deal of difficulty in keeping awake, and could forestall these attacks of diurnal sleep only by keeping herself extremely busy. She was particularly prone to fall asleep after lunch, and diminishing the amount of food she ate did not lessen this tendency. In the evening she often fell asleep in her chair, waking up to find that she had missed the radio program she had intended to hear. She fell asleep while people were talking to her, and often incurred her sister's anger on this account.

At the age of 21 she began to have cataplectic seizures which have occurred six or more times a year. They take place under two sets of circumstances: whenever she laughs heartily over an amusing incident, or when she is intensely interested in hearing or telling a story. During a visit from a favored aunt with whom the patient likes to talk, she had three cataplectic attacks on three successive evenings, while engaged in conversation with this aunt. The attacks begin with a peculiar sensation in the lips and tongue; the tongue becomes "thick" and it is very difficult for her to talk. This is followed by a feeling that her legs will not hold her, and unless she lies down promptly, she falls to the floor. She is unable to prevent these attacks of flaccid paralysis, which last about five minutes. During this time she is perfectly conscious, unable to move any part of her body, knows what is going on about her, and wants to talk but is unable to say anything. There are no sequelae, other than psychological, to the attacks. They have always occurred in the presence of other people, and cause the patient much embarassment. She always attempts to make the seizure look purposeful, as though she had intentionally slumped down in her chair. Once while putting her young nephew to bed, and while

laughing at the antics of the child, she felt an attack coming on; she tried to stay herself from falling by holding on to the crib, but when this was not possible, she tried to act as though she had sat down on the floor because no chair was available. Others, however, always detect the pathological nature of the event.

The patient has had attacks of sleep paralysis which occur only after the diurnal naps. On awaking from such a sleep, she occasionally finds herself unable to move any part of her body, although she is fully conscious. These attacks last, on the average, about five minutes. Her nocturnal sleep is sound, and she says that she is rarely disturbed by dreams.

Examinational data: Psychiatric examination revealed a timid, blocked and embarassed woman. Her voice quavered, she was not easily accessible, and it was difficult to elicit information from her. She felt that examination by a psychiatrist carried a stigma with it, and it was only upon her brother's insistence that she had a neurologic disorder of which she need not be ashamed, that she agreed to seek help.

Aside from her concern over the attacks of sleep and muscular powerlessness, she said that she had only one emotional problem. She earnestly desired to get married and have a family but deplored the fact that opportunity for these gratifications was rapidly waning. The church did not approve of her marrying a divorced man, and she was reaching the age at which she could not bear children. Many men had shown her attention, but she had never been able to get interested in any of them. Her sexual life had been extremely inhibited. She said that she had never masturbated. Although she felt that she had powerful sexual urges, she would allow herself to engage in no sexual activity until marriage. She felt that under proper circumstances she could enjoy sexuality, because the Bible tells us to "increase and multiply." When men made advances to her she vigorously discouraged them, and did not feel at ease until they desisted. She was much preoccupied with phantasies of what sexual activity would be like, but tried to stifle these day dreams lest they make her situation worse. She feared that, unless she married, she would have to face the unpleasant eventuality of living alone; she would not live with her brother or sisters, since that would make her feel dependent on them.

The neurologic and psychiatric diagnoses were: narcolepsy and cataplexy; inhibited personality.

Psychologic tests showed a neurasthenic-like condition in an extremely inhibited person. Bodily preoccupations were outstanding, and a paucity of ideation was shown. Some suspiciousness and prudishness were evident. On the Bellevue Scale, the patient obtained an intelligence quotient of 119, 91st percentile, bright normal intelligence range. The scatter was minimal. Attention was undisturbed, while verbal concept formation

was mildly impaired. The diagnostic personality tests showed the widespread inhibition, stereotypy and meagreness of productivity.

Physical examination showed a well developed and well nourished woman, five feet, six and three-quarter inches in height, weighing 134 pounds, in good general health. Neurologic examination was negative, except for tremors of the eyelids, a tonic reaction of the pupils to light, and poor ocular convergence.

Red and white blood cell counts, differential count, and hemoglobin determination gave normal results. The sugar tolerance test showed an unusual curve: the fasting blood sugar level was 93 mgm. %; one-half hour after the ingestion of 100 gms. of glucose, the blood sugar level was 131 mgm. %; one hour, 95 mgm. %; two hours, 147 mgm. %; three hours, 120 mgm. %; four hours, 140 mgm. %; five hours, 93 mgm. %. X-ray of the skull revealed no abnormalities.

Electroencenhalogram: The report was as follows:

A symmetrical record containing a fair amount of good alpha activity (in long and short runs) interspersed with low-voltage fast activity. Abnormal activity was seen in nearly all leads and occurred in bilaterally symmetrical bursts: a fronto-vertex tracing contained a burst of 10 spike-and-wave complexes of 4 to 6 per second frequency and of about 100 microvolts amplitude, while a simultaneous left central-vertex tracing contains two in-phase spike-and-wave complexes of 40 microvolts; a parieto-occipital tracing contains a 3 second burst of 6 to 8 per second waves with one wave of 4 per second, all of 50 to 75 microvolts. In the apnoeic period following two minutes of hyperventilation two separate four second bursts of 3 per second, 75 to 100 microvolts spike and wave activity appeared in both fronto-indifferent leads, while simultaneously a few 6 per second waves of 50 microvolts appeared in both occipito-indifferent leads. A hypothalamic lead contained no abnormality. On stimulating the right carotid sinus single waves and brief bursts of 3 per second activity appeared in both fronto-occipital tracings; left carotid sinus stimulating produced no effect.

Conclusion: An abnormal record containing paroxysmal discharges of grand mal and petit mal type. No focus was suggested. Right carotid sinus sensitivity was indicated as a trigger mechanism.

Comment

Like one of the patients with narcolepsy reported by Chodoff[25], this patient had attacks of loss of consciousness, lasting a few minutes, and not accompanied by convulsive movements nor loss of sphincter control. Such attacks are, of course, suggestive of a convulsive disorder. Further indications, adduced by this case, of a relationship between narcolepsy

and the convulsive disorders, are the abnormal patterns in the electroencephalogram. There is evidence of hyperactivity of the carotid sinus reflex, as was observed by Wilson and Watson[26] in cases of narcolepsy. So far as the author has been able to determine, this is the first instance in which the petit mal pattern has appeared in the cortical electrical discharges of a narcoleptic patient. Walker *et al*[27] were able to produce the hump and spike pattern in the electroencephalogram in their experiments on photic driving. It appears that when photic stimuli to the retina take place at a frequency considerably slower than the normal alpha frequency, then the abnormal hump and spike form occurs. The cortex, accustomed to discharging at a certain rate, produces abnormal patterns when driven to discharge at a slower frequency[28]. The wave and spike forms in the electroencephalogram of the patient herein reported can be looked on as the result of the inhibitory processes which were clinically so evident. The diminished frequency of cortical discharge, and the emergence of the abnormal wave and spike form, may well be the physiological concomitants of the emotional inhibition manifested by the patient. It is apparent that at least in some cases of narcolepsy in the waking state, abnormal cortical discharges occur, resembling those seen in the convulsive disorders, and in the present instance, the typical petit mal pattern appeared at times.

In view of the frequency with which the diencephalon and the areas surrounding the third ventricle have been considered by various authors[2, 10, 18, 29, 30] to be the site of origin of the narcoleptic disturbance, it might be thought rather surprising that the hypothalamic lead in this case did not show further electroencephalographic evidence of disordered function. However, Davison and Demuth[31] have shown that injury to certain cortical areas or their connections with the hypothalamus is occasionally the cause of pathologic sleep. For those who believe that dynamic emotional forces play a rôle in the production of the narcoleptic attack, and they must certainly be in the majority, the theory that the sleep disturbance arises in the cerebral cortex is in conformity with the view that the narcoleptic seizure is mediated, at least in part, through psychologic and emotional events. Worster-Drought[23] says that, "Of those cases of narcolepsy which are independent of organic disease and which might be termed 'functional,' the cases I have encountered lead me to believe that there are several varieties, each corresponding with a different psychological level ranging from superficial to deep until a form is reached, the reaction of which occurs at a purely physiological level." He considers some of the varieties of narcolepsy to be forms of conversion hysteria, and compares others to the "psychasthenic convulsions of Oppenheim or the compulsion neuroses." Levin[32], too, was of the opinion that cortical dysfunction released the

narcoleptic symptoms. He said: "The attacks of sleep of narcolepsy occur with significant frequency under conditions duplicating those which in Pavlov's experiments elicited sleep and other manifestations of cerebral inhibition. This, together with other evidence, suggests that narcolepsy results from a disturbance (in the cerebral cortex or elsewhere) which renders the cortex unduly exhaustible or 'inhibitable', the attacks of sleep arising from inhibition of the whole cortex and the attacks of flaccid paralysis from inhibition of just the motor cortex (plus, probably, certain subcortical motor centers as well)."

The patient reported above could not resolve her emotional conflicts, which brought her to such an impasse that she led a markedly inhibited life. Levin[23] commented on "the tendency of narcoleptics to fall asleep when faced by unpleasant situations from which they would like to, but cannot or dare not, escape. Langworthy and Betz[24] stated: "Patients showing the narcoleptic syndrome have in common a characteristic background of emotional conflict. They feel caught in a life-pattern to which they are expected to conform, but which they deeply resent. They become motivated by a need for autonomy and for self-differentiation along the lines of some alternative life-pattern of their own choosing. They are frustrated in their efforts to achieve this, because of the actual psychological ties which bind them to the life-pattern which they feel impelled to reject. In the tensions of the resulting emotional dilemma, the narcoleptic symptoms appear."

This concept of the psychogenesis of narcolepsy is borne out by the facts of the case reported herein. The identification with the aggressive, overly religious and compulsive mother determined the patient's patterns of behaviour. The hostility in this identification was apparent in the fact that the patient carried out her mother's precepts to such extreme degree that even the mother was annoyed. The patient was frustrated by the orderly routine of her daily life and by the too literal application of religious teachings. Yet, shackled by the strong attachment to her mother, she could not break her bonds and escape into the marital release she desired. It was at the time, in early adult life, when the desire to escape from this situation became prominent, that the narcoleptic symptoms made their appearance.

Summary and Conclusions

1) A case report of a patient with narcolepsy and cataplexy is presented, the pathogenesis of which is attributed to the emotional conflicts of the patient.

2) The psychologic processes have their neurophysiologic counterparts,

as detected in the electroencephalographic record and in the clinical symptoms.

3) This is the only case of narcolepsy so far reported in which a petit-mal pattern appeared in the cortical cerebral discharges.

4) At least in some cases of narcolepsy, there are neurophysiologic similarities to the convulsive disorders.

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BOOK NOTICES

Modern Attitudes in Psychiatry; The March of Medicine, 1945. Number X of The New York Academy of Medicine Lectures to the Laity. Price $2.00. Pp. 154. New York, Columbia University Press, 1946.

For ten years The New York Academy of Medicine has arranged for a series of lectures to the laity each year. For 1945 this series of lectures was appropriately devoted entirely to psychiatry. An excellent historical sketch of psychiatry was given in two lectures by Iago Galdston of The New York Academy, and Dr. James H. Wall of The New York Hospital. Canby Robinson of the American Red Cross discusses the social aspects of illness; General William C. Menninger, military aspects of psychiatry; and Edward Weiss of Philadelphia, the use of psychotherapy in general practice. Franz Alexander contributes a chapter on present trends and the future outlook.

In the opinion of the reviewer, the historical lectures and the discussion of military psychiatry are the best chapters, but the whole book is interesting, lucid and informative—well adapted for lay reading, but good for doctors, too. (K.A.M.)

Rehabilitation—Its Principles and Practice. Revised and Enlarged Edition. By John Eisele Davis. Price $3.00. Pp. 260. A. S. Barnes & Co., Inc., N. Y., 1946.

"A new psychology of rehabilitation is needed, an aggressive psychology away from the defensory custodial ideals typified in the old hospital system. . . ." For better understanding of this "new psychology" the author has presented, almost in textbook form, a survey of theories applying to the total job of rehabilitation in the field of mental illness from the approach of the psychiatrist, the physician, the psychologist, and the various kinds of occupational and recreational therapists.

At a time when much is needed in the way of sound orientation to the job of rehabilitation, this book should be of considerable interest. Not only does it view rehabilitation theory as a dynamic moving thing that must operate in line with the immediate social interrelationships of a society, but it stresses the needs of the individual as primary. On an educational level, the author holds out to society the need for fostering affection of workers for employers as a means of assisting sublimation of aggressive impulses; and for the rehabilitator specific methods of rehabilitation are discussed and documented by quotations from experienced persons in the field. Frequent case reports are presented with a plea for the need of greater dynamic understanding of the various types of illness. (Annette Renaud.)

Hypnoanalysis. By Lewis R. Wolberg. Price $4.00. Pp. 360. New York, Grune and Stratton, 1945.

This discussion of "hypnoanalysis" is probably the best work on the subject thus far published. Although in his techniques Doctor Wolberg is bold and imaginative, his conclusions are cautious and eminently reasonable.

The book consists of two major sections: (1) The presentation of an illustrative case with a case analysis by A. Kardiner; (2) Chapter discus-

sions of the problems of transference, resistance, interpretations, etc., in hypnoanalysis. Perhaps one of the weakest points about this volume is the fact that the discussion of transference, resistance, interpretation, and so on, is really not specific to hypnoanalysis. It is as if an attempt were made to combine a discussion of hypnoanalysis with the more general problems of technique in psychoanalysis. Although the problems are often very much the same, one would hope to hear more pointedly from such a presentation the crucial differences between the two rather than their similarities.

In an area of investigation where there is such a plethora of either exceedingly dull or exceedingly irresponsible presentations, it is a relief to read an account which in spite of its many limitations is an honest and modest statement. (M. Brenman.)

The Biology of Schizophrenia. By R. G. Hoskins. Price $2.75. Pp. 191. New York, W. W. Norton & Co., 1946.

This book is a concise report on the results of 18 years research by a competent team of investigators led by the author, in connection with the Worcester State Hospital. The author's approach to the problem is primarily biological. The first lecture is an introduction into modern theory of knowledge. Hoskins follows the theory of "emergence" in biology, investigating the different "emergent levels"—molecular, cellular, glandular, homeostatic, finally to reach the level of personality integration. Hoskins and his co-workers found a significant sluggishness of adaptation to the internal and external environmental stresses in schizophrenia. Among other things this expresses itself in reduced oxygen uptake of the tissues, in vestibular impairment, disturbed utilization of certain hormones and vitamins. The otherwise elastic adjustments of homeostasis become in schizophrenia at times "robot like". The ultimate location of all the disturbances of vegetative equilibrium in schizophrenia might be caused by enzymic changes in the hypothalamus. However, the crucial question whether similar vegetative maladjustments could also be caused by psychogenic factors or not remains unanswered. In maturity, the pernicious lack of self-esteem and of empathizing ability are stressed as the outstanding aspects of the schizophrenic personality.

It is a pity the author felt it necessary to slash out against psychoanalysis, conceding however, its indispensability for the psychological understanding of schizophrenia.

The therapeutic suggestions for further research contained in this book are most challenging and stimulating. It is recommended for everyone interested in the problem. (Jan Frank.)

The New Veteran. By Charles G. Bolte. Price $2.00. Pp. 212. New York, Reynal & Hitchcock, 1945.

This book describes the beginnings, the ideals, the purposes of a group of veterans which may become one of national importance. It is the only veterans organization which adheres to completely democratic plans of membership and administration; for example, it draws no color line in its units. Mr. Bolte lost a leg in the African campaign and during his convalescence began to think about the problems of re-assimilation when he and his companions returned home. He thought bravely, clearly, and constructively. (K. A. M.)

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PSYCHIATRY IN FRANCE*

By PIERRE D. FOUQUET, M.D.†

A brief historical review of French psychiatry may be helpful in understanding the present situation of psychiatry in France. We can say that the evolution of French psychiatry and American psychiatry has been roughly the same; I mean that they have moved in a parallel direction. I was particularly impressed by the fact that both the American Psychiatric Association and the Medical Psychological Society of France were founded at the same time and that each published at the same time, a hundred years later, a special book commemorating one hundred years of psychiatry. I believe, however, that the American effort is definitely ahead of the French at this time.

I

After the spectacular and emancipating action of Pinel in the beginning of the 19th century a number of French psychiatrists attacked the problem of mental illness. Their efforts resulted in the passing of a law in 1838 on the treatment of mental illness, which was the first social welfare law of France. This law was not inspired merely by the fear of the so-called lunatic, but also by the concept that people who are mentally ill deserve treatment. Surprisingly, provisions were included for the commitment and the discharge of the patient, which constituted a revolutionary step, since the principle of French law has always been to guard individual freedom. For the first time, because of the concept of disease, a mentally ill person could be deprived of freedom, both physically and legally. It was already understood that he had to be treated and at the same time that his personal property was to be safeguarded. This law made it

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compulsory for each French department, which is roughly equivalent to a state in America, to establish an institution for the care and treatment of mentally ill patients.

The main work of French psychiatrists up to the end of the 19th century was the description and classification of the different states of "insanity," and I believe that their descriptions are still good today. Esquirol, for instance, described the principal types of psychoses as we know them today. As early as 1822 Bayle in Charenton had described for the first time general paresis and wrote his thesis on meningo-encephalitis. Morel in the middle of the 19th century was the first to describe a type of dementia in young people and he named it dementia praecox. Up to Magnan, French psychiatrists kept trying to define and isolate mental diseases in parallel with somatic diseases, under the influence of the general concept of general paresis. Because of Bayle's general paresis description showing that one type of mental illness was due to a specific organic disease French psychiatrists were led to believe that sooner or later all mental illnesses would surely show a physical etiology as well. Charcot at the end of the 19th century studied neuroses, but he was also a neurologist and organicist. The portion of his work concerning neuroses was violently attacked by the neurologists who followed. For instance Babinski, when he first described his sign, insisted that this was objective, that we could build on such objective material a scientific neurology, and that the rest was more or less metaphysics, more or less mythical.

Before Charcot several French authors, such as Itard, Seguin, and Bourneville had already established the first principles of child psychiatry.

II

At the beginning of the 20th century French psychiatry began to decline. Among the reasons for this decline were the discoveries of Pasteur, the development of bacteriology and other laboratory techniques, and the birth of modern surgery with emphasis on physical medicine—physicians believed then that medicine was becoming an exact science. Many young physicians were attracted by this promise. In the country of Descartes the relation between the physical and the mental was considered from the viewpoint of dualism. Psychology itself became a laboratory and esoteric science which claimed to make precise measurements. An important portion of psychology lost touch with humanity. For these reasons and others a public interest in mental diseases and human mental processes in general began to wane. As a result French psychiatry shut itself into the lunatic asylums, which were generally built away from cities and isolated from normal social life, and concentrated on the committed patients.

III

Yet in that same period, I mean the beginning of the 20th century, there were in France some psychiatrists and psychologists who studied the problem as a whole and built a dynamic work which even now retains a certain value and appears definitely modern. For example, the important work of Pierre Janet was published in the first quarter of the 20th century. Let us recall that the first I.Q. tests were established and formulated in France by Binet, a French psychologist, and Simon, a French psychiatrist. In that same period Toulouse, a French psychiatrist, established the first basis of mental hygiene in Europe and at the same time that Clifford Beers was establishing a Committee for Mental Hygiene in the United States, Toulouse in France was establishing a league for mental hygiene and creating hospitals for voluntary patients. In spite of these few workers that I have just mentioned, however, French psychiatry was on the decline and German psychiatry was leading; for instance, Kraepelin with his synthesis of dementia praecox, Bleuler with his concept of schizophrenia and finally Freud.

IV

Let us consider now the situation of psychiatry in France following World War I. The final expression of somatic, mechanistic, atomistic, nosologic psychiatry was formulated by De Clerambault. Since 1925 new doctrinal tendencies have appeared in French psychiatry, particularly the works of Henri Ey who applied to psychiatry the dynamic principles of Jackson as he used them in neurology. He has not completed his work but he is having a very strong influence on French psychiatry because he has in the last 15 years trained perhaps 30 percent of the young French psychiatrists. His doctrine is organo-dynamic and monistic. He claims that mental diseases do not exist as entities and that all the different states of psychosis represent different levels of mental dissolution, and regression; in every state of mental disturbance, even in the slightest, he considers that there is a positive part and a negative part, the positive part being that which persists and the negative part being that which has been destroyed. The patient has to reorganize his mode of living, his social relationships, his personal being and his somatic being. This school has already produced a certain amount of work, the tendencies of which are fairly close to those of American psychiatry.

In child psychiatry the school of Heuyer has made progress in its efforts to have this problem recognized as an essentially medical and social one. However, the principal tendency of French psychiatry is to remain essentially somatic: in experimental research, body structure and measure-

ments, pathological anatomy, biological research, endocrinology, etc. For example, the hypothesis on the part played by the mesencaphalon in the etiology of mental diseases: biological research on the post-electric shock syndrome which tend to prove that the mesencephalon is principally involved, and encephalography, are done at the Sainte-Anne hospital in Paris, under Professor Delay. Therapeutics, such as malaria therapy, insulin therapy, shock therapy, narcotherapy and the applications of neurosurgery are essentially the same as in the United States. The research work concerning psychotherapy and social psychiatry are definitely far behind the developments we see in America. Psychoanalysis has been relatively slow in penetrating psychiatric circles in France.

At the present time and as a whole the problems confronting French psychiatry are essentially the same as here in America.

(a) The elaboration and construction concerning the essence of psychiatry, its real meaning; in other words, what is psychiatry and what should its role be in our modern social life?

(b) The education of psychiatrists, under-graduate and post-graduate training, and the orientation of general practitioners, nurses, social workers and the general public. Let me put in a parenthetical statement to give you a few facts about the training of medical students in France.

The study of medicine requires six years, preceded by one year of preparatory biology, physics and chemistry. The student must also have an A.B. or B.S. degree before he can enter a medical school. The clinical teaching is given every morning in hospitals, and practical work such as dissection, laboratory techniques, etc. and also lectures by professors, are given in the afternoon at the medical school. The best students have the opportunity to enter a special contest, usually during their fourth year. If they succeed they become "interns" in teaching hospitals for four years. This title is misleading and corresponds to "resident" in the United States. At the end of the 4th or 5th year the students have generally decided whether they will practice general medicine or a specialty.

The students who do not pass this special test (which is not compulsory) must then spend one year in a hospital. This corresponds to the American internship with the difference that, since, during the five preceding years, they have already spent every morning in hospitals, rotating to cover all the branches of medicine and surgery, they are allowed to choose, for the 6th year, the field they are particularly interested in. Finally, the student must present a thesis which is a personal, original work on a subject selected by the student. This thesis, which is generally from 50 to 100 pages, is printed. The student discusses this thesis in a public examination conducted by three professors. When this thesis is accepted, the student is then given his M.D. degree. This degree gives him automatically a

license to practice every branch of medicine, obstetrics, and surgery in the whole of France and its possessions.

As for the teaching of psychiatry for undergraduates, it is during the 5th year only that they receive it. It consists of six weeks of hospital attendance with clinical teaching and lectures. The post-graduates who wish to specialize in psychiatry enter a competitive examination to secure residencies in a psychiatric hospital. The usual length of this residency is four years during which they study in more detail anatomy and physiology of the central nervous system and psychiatry. The emphasis, in France, is on the personal clinical work. We have excellent lectures but a great latitude is left to the student in the choice of his personal psychiatric orientation. Few students are psychoanalyzed.

Continental France has 28,000 physicans and there are only 350 psychiatrists for a population of 40,000,000. French speaking psychiatrists meet once a year, in France, Belgium, Switzerland or North Africa. Many foreign psychiatrists attend, representing generally about 40 nations.

The three main psychiatric journals are:

1. *Annales Medico-Psychologiques*—a monthly publication which is 102 years old.

2. *L'Encephale* and its supplement *l'Hygiene Mentale*, also a monthly publication with a somewhat neurologic orientation.

3. *L'Evolution Psychiatrique*—a monthly also with a dynamic and psychoanalytic orientation. We must add *La Revue Francaise de Psychonalyse*. The last three could not be published during the occupation on account of paper shortage. They are now resuming publication.

The text books on psychiatry for undergraduates are relatively meager as there have been no new editions in recent years. But some excellent monographs are published every year on such subjects as psychiatry, psychology, and neurology.

V

After this long parenthesis, let us continue with the problems confronting psychiatry proper.

(c) The application of our present knowledge to practice. I mean the application of our present knowledge to the care of patients in already established psychiatric hospitals and introduction of new principles in establishing new hospitals. I mean also the application of new doctrines in the social welfare plan. For example there are at the present time 624,000 mental patients in the United States hospitals and there is no doubt a considerable gap between the treatment that we know these patients should receive and what they are actually receiving. In the United States the general tendency, which has been realized in a few states only, such as

New York, is to have specialized psychiatric hospitals: mental defective, epileptics, criminally insane, alcoholic, drug addicts, and of course psychoses. Inside these hospitals, the psychiatrists are strictly hierarchized and the fragmentation of work is usually carried very far. For instance, the patient is, on admission, examined by a psychiatrist, a psychologist and an internist. He is then sent to a particular building in the care of a particular psychiatrist who, however, will send him to other psychiatrists for particular treatments such as insulin therapy; he may also be referred to a psychotherapist. The orientation towards huge psychiatric hospitals such as the Pilgrim State Hospital in New York with 9,000 patients, was dictated by economic considerations. But this orientation is now considered poor by most American psychiatrists. In most cases, the patient to be committed must be referred to a special court.

In France there are 97 psychiatric hospitals and they seldom have more than 2,000 beds. They are organized in small units, each having a medical director assisted by residents. Each medical director is responsible and has full authority in his unit. He makes all decisions, diagnoses, transfer, treatment, discharge, etc. In each small unit, all types of patients may be found. The patients are, of course, placed according to their behavior, the disturbed separated from the depressed patients, i.e., the patients at the limit of sociability are segregated in special pavilions. The ideal is to reconstruct a new society, close to real life, without considering the nosologic label. They are housed, not in a big hospital building, but in small treatment units arranged rather like a small town for the resocialization of the patients. This allows the admission of all types of patients, alcoholics, epileptics, mental deficiencies, psychoneurotics, and psychotics. But I repeat that, of course, the idiots and imbeciles or the very severe cases of epilepsy where treatment fails to bring any improvement, must be and are segregated.

The interpersonal relations are studied so that the patients can help one another, which constitutes an indirect and active form of psychotherapy. Work therapy is used and many patients, men and women, work in farms and workshops, either in the hospital or outside. Finally there are "familial colonies," different from the American "family care" in the sense that there are whole villages in which the patients mix with the normal population and work (generally at farming) under psychiatric supervision. In brief, there is no specialization in French psychiatric hospitals, no hierarchy between the medical directors, no fragmentation or dispersion in the relations between the patient and *his* physician. The psychiatrist can, of course, ask for consultation from internists, surgeons, etc. The medical director does not use the psychologist routinely, but there are psychologists who do some research work. Almost every department has a public psychiatric hos-

pital, connected with the Health Center where there is an outpatient service for children and adults. It is also connected with general hospitals. After his discharge the patient is followed up by the social worker. This organization, however, has not yet been realized everywhere, for, like the United States, France suffers from a shortage of trained personnel, psychiatrists, psychiatric nurses and psychiatric social workers. During this war juvenile delinquency has increased markedly and now a special department is coordinating the efforts of the Department of Justice, the Department of Public Health, and the Department of National Education to obtain a better approach to this problem.

In France before this war there were 120,000 mental patients in hospitals and the care they received varied from good to poor according to the hospital. Concerning the protection of the mental health in social life penetration of principles of mental hygiene is still comparatively poor. The relations that psychiatry must establish with related sciences are still considerably underdeveloped in France.

As these tasks confront us, I am glad that I find in both France and the United States the same urge to enact new laws. A proposed bill, now pending in France, covers the same ground as the National Mental Health Act which is before your Senate. There is, however, one essential difference in the French bill which proposes a new mechanism for commitment of voluntary patients.

At the present time the general problem in France is reconstruction. We, the French psychiatrists, want to re-construct French psychiatry so as to insure better protection of mental health, both for the child and the adult. The proof that mental hygiene is a social problem can be found in the fact that during this war juvenile delinquency has increased considerably whereas both psychosis and neurosis have, on the contrary, decreased markedly. The causes of juvenile deliquency are fairly obvious. The family was disrupted, the conditions of life deteriorated, and war and military occupation brought general insecurity. On the other hand, adult people with slight neurotic states, when they are confronted with definite objects of love and definite objects of hate, can find a sort of satisfactory adjustment and it is obvious that the German soldier was an easy object for hatred and the Allied soldier an easy object for love.

While we are waiting for the role that psychiatry will have to play in international relations and for a better order in the world, I am happy to see that the relations between French and American psychiatry are improving, and that five French psychiatrists have come to America, sent by the French government. I hope that in the near future American psychiatrists will be better informed about the condition of French psychiatry and that a mutual exchange of publications will be permanently established

SOME ESSENTIALS IN NATIONAL MENTAL HEALTH PLANNING*

By DANIEL BLAIN, M.D.†

When eight million people‡, constituting six per cent of our nation's total population, are suffering from some form of mental disease or personality disorder, the branch of science devoted to that group of diseases finds itself facing an overwhelming responsibility. And when the six to eight million families of these people are affected by their sick relatives, a large and important portion of the total population is profoundly disturbed. It becomes not only a problem of medical science, but one related to all groups of society.

Accounting for over half of all hospital beds in the civil population, and the larger part of the medical and disability discharges from the armed forces, psychiatric problems are obviously swamping the medical profession. Psychiatry and the medical profession (and I include all specially trained auxiliary groups in the medical profession) are in both an enviable and dangerous position today. Faced with the task of stemming a rising tide, they have a glorious opportunity for national service. If, however, they fail to exert leadership and deal successfully with mental diseases and maladjustment, the prime responsibility will be taken away and will fall into the hands of others.

The problem is of the group rather than the individual. No illnesses are so related to the interplay of an individual and his environment, as those in the mental and emotional field. With this in mind, it is appropriate to speak of national planning—for any plan to eradicate mental and emotional illness is national in scope, in distribution, in size and in importance.

It is well at this point to suggest an orientation toward the problem which I believe is important. Our attention is traditionally focused on the six per cent who are sick. It is the 94% who are well, who are the most important. Planning for mental health must emphasize a positive concept of *health* rather than the negative concept of *disease.*

Planning for Veterans

The Veterans Administration has among its beneficiaries a large portion of the adult male population. Its psychiatric problem is quite similar to that of the nation, in that sixty per cent of its beds are devoted to neu-

* Read at Annual meeting, National Conference of Social Work, Buffalo, N. Y., May 21, 1946.

† Acting Assistant Medical Director for Neuropsychiatry, Veterans Administration, Washington, D. C.

‡ Hearings Neuropsychiatric Institute Bill and Social Security Board (private communication).

ropsychiatry, and three out of five claims for disability pensions are neuropsychiatric in origin. Neuropsychiatric hospitals now contain about 50,000 patients. It is estimated that 200,000 beds will be needed by 1975, at which time the peak load should be reached. Estimates of those needing outpatient care are vague, but are based on the 581,000 discharges from the services for mental condition and inaptitude. In a survey just completed in a small eastern state, out of 2600 receiving pensions for psychiatric disorders, over 50% needed outpatient treatment and would have benefited from it, in the opinion of the psychiatrists making the examinations. It is estmated that one hundred thousand need treatment now.

In the last few months efforts have been made in the Neuropsychiatric Division of the Veterans Administration, not only to handle the immediate hospital emergencies, but to lay a broad and solid foundation for effective work over a period of years. Although the Federal Government has by Congressional action fixed the responsibility for 20,000,000 veterans on the Veterans Administration, the very nature of the disease precludes independent planning. The shortage of all facilities indicates a sharing of all assets—just as the general causes operating to produce neurosis are common to all members of the total population. Veterans are a part of the general population. Efforts on our part in care and prevention will be of no avail unless they are matched by similar efforts throughout the country.

We in the Veterans Administration are interested in giving "good medical care" and all that that implies We are now working on improvement of present hospitals as regards more personnel and better equipment; new hospitals with the most up-to-date architectural plans; location in areas near medical schools and associated with them; creation of a chain of mental hygiene clinics adequately staffed with social workers and clinical psychologists; arrangements with all grade A medical schools to start postgraduate training for specialization in psychiatry. We have about 100 residents now and hope to reach 6–800 within a year. Almost all Veterans Administration hospitals and mental hygiene clinics will be made into teaching centers. Money is available for research both of clinical and laboratory type.

In facing a desperate situation filled with emergencies, critical shortages in personnel, we have found great deficiencies in knowledge and very little leadership on which to lean in solving a whole series of major problems. With billions of the people's money going to be spent, it is an awful obligation to see that it is spent wisely. With thousands of our best young men needing immediate definitive treatment, we are impressed with the necessity that methods and techniques shall be right—that these men shall not say years later: "If I had only been treated in time. If I had

only had something better than was offered—I would not be as I am now." So we are asking ourselves many questions. Our suggestions for national planning come in the form of queries. I am not giving the answers. You will see where we are puzzled and looking for help.

(1) What is the real nature and extent of the psychiatric problem of this country? This demands a thorough, comprehensive survey. No effective plan can be devised until the problem is defined, understood and evaluated. Statistics are uncertain, often based on changing nomenclature. The emphasis has been on psychotics, yet the great burden of the load is in the field of the neuroses and maladjustment. The extent of these conditions is almost completely unknown.

What do we know of the extent and nature of mental disease and personality disorder in children, young and aged adults, and the relation of one to the other? Of reactions in various races found in this country? The effects of national strains mixing to form the average American? Have we any comparison of those who are rich, poor and intermediate? The literate as compared to the illiterate? Those of superior and lesser intelligence; the urban and the rural; hot and cold parts of the country; the various groups of employed—farmers, miners, seamen, white collar workers, day laborers, migratory groups, tramps?

Much could be gained by comparing our situation with that in other cultures, studying the effects of fatalism, comparing the incidence and nature of mental disease in countries dominated by various religions such as Buddhist, Mohammedan, Christian. I have been told that there is no mental illness to speak of in the Near East. Is this true, and if so, why? Does the youth or age of a country have a bearing on the precipitation of mental disease? Are we softer and more vulnerable than in pioneer days? Do the enthusiasm and grandiose ideas of those from a pioneer state like Texas, added to superior wealth and natural resources of the state, make Texans more immune to neuroticisms, or less immune?

What about national trends? Do they affect the incidence of nervous breakdown? Are rugged individuals tougher than the proponents of a "strong White Father in Washington" who gives security to all? Is the modern concept of welfare work as found in the policies of the Social Security Board as good as it appears to be, or should we expect further modification with the passage of time? Are backers of free enterprise different in emotional makeup from advocates of totalitarianism?

I am suggesting that we learn more about what is called the group; that we integrate the work of anthropologists, sociologists and psychologists, concerning mass reactions; the effect of inter-personal relationships; the effect on man of belonging to a society and how the intimate details

of that society with its inheritance, its mores, its protective mechanism affect men singly or in large numbers. We would know the various factors operating to influence or produce mental disease and personality disorder.

A comprehensive survey on all factors such as those mentioned above should be planned to extend over a longitudinal section of the nation's life. It should be in the hands of a committee of experts, representing all phases of society. It should work for five or ten years and come out with reliable information.

(2) What are the available assets? An early part of a planning program would be a study of available assets. All hospitals in the country—state and federal hospitals and private hospitals—should be surveyed to determine exactly what is going on. It would be valuable to get together the good points and bad points of existing institutions. See what is needed to bring them up to a set standard, in equipment, personnel, treatment methods. Perhaps a coordinated effort would succeed better than isolated individual efforts. Such a coordinated drive might produce an increase in state and federal appropriations—certainly it would aid in a proper sharing of what little personnel and money there is. Duplication in special projects could be prevented, greater teamwork inaugurated, more personnel trained and better care of patients achieved. If the present method of cost accounting could be changed from cost of patient per day to cost per patient per treatment period, it would be shown that economy that prevents adequate treatment and produces permanent hospitalization is false economy in the long run.

(3) What are the functions of each of us in solving the problem? In long-time planning for mental health, it is important to know who is responsible for carrying out any plans that may be devised. Does mental disease belong with tuberculosis and venereal disease as a major public health hazard, to be turned over to the state, as they are? Should mental health be the responsibility of government, professional or volunteer organizations, or individual doctors? If government, should it be federal or state or country or municipal? Among organizations one thinks of specialty groups, representing psychiatry, neurology, psychology, nursing, social work, and similar organizations, physical medicine, occupational therapy, dietetics, also the National Educational Association. There are the two great volunteer groups—National Committee for Mental Hygiene and the new National Mental Health Foundation. Alcoholics Anonymous is making a great contribution in one field. There are the great foundations, contributing to medical problems of their own choice. There are the great religious bodies exerting a profound influence on human behavior and welfare; the fraternal groups—Masons, K of C, civic groups, veterans'

organizations; great bodies of organized labor and the rapidly organizing employer groups with their interest in the welfare of the constituent members.

(4) What are the proper functions of various professional groups? Much clarification needs be given to the problem of who is authorized to treat mental disease and personality disorder. The present status of those assuming a therapeutic role is confused. Doctors are legally entitled to practice medicine and surgery—these terms include all specialities in the medical profession. And in some states psychologists are licensed to engage in private practice, the nature of which is not well defined. Others are also interested in treatment phases, especially in psychiatry—social workers and psychologists feel they should be assigned a therapeutic role and not be treated as technicians only. It is obvious that the real pleasure in medical activities is in the patient-doctor relationship, and having a share in working with the patient directly. This is understandable, and should be recognized.

In the Veterans Administration we have arrived at a decision as to what part in the therapeutic process is to be assigned to clinical psychologists and medical social workers. The essence of the position we take lies in the training and experience and ability of any individual clinical psychologist or social worker We recognize the position that each worker desires, assign a share of therapeutic responsibility and place limits on the extent to which non-medical people shall go. The doctors have made the decision as to when to delegate responsibility because under present laws this responsibility rests with us.

(5) What is the value of the team concept? A most important concept in modern psychiatry is the use of teamwork in giving the patient "good medical care." Modern diagnosis and therapy is not best accomplished by an individual psychiatrist. All patients need careful social service and psychological work-up and follow-up. Nursing is essential in hospitals and the visiting nurse outside. A skilled psychiatrist who knows the functions of the nurse, social worker and clinical psychologist, and has some experience in group work, can adequately handle five to ten times as many patients as he can alone. He can not only care for more, but the quality of care is markedly enhanced. Outside of the inner circle of four I have mentioned, the team also includes all the groups of people who come in contact with the patient—in hospital gatekeepers, guards, receptionists, volunteers, those in occupational therapy and physiotherapy, recreation specialists, the families of the patients.

(6) Where does psychiatry belong in the field of medicine? Any plan for meeting the psychiatric problem of the nation should include the proper orientation of psychiatry in the medical world. Modern concepts in psy-

chiatric treatment call for less isolation, more participation by men in other specialties, more emphasis on early acute treatment, more of what in the war has been called rehabilitation to start with earlier phases of convalescence. As more and more emphasis is placed on psychosomatic conditions, it is more than ever necessary for psychiatrists to be in close contact with all branches of medicine and surgery. This makes for better psychiatry, better medicine and surgery, and better doctors in all fields.

Furthermore, all doctors should have a great deal more psychiatry in undergraduate medical schools, and all postgraduate specialization should include a large amount of psychiatry, even in the sub-specialties of medicine and surgery. General practitioners, in particular, should have considerable training in psychiatry. They probably see the bulk of nervous cases, and almost always see them first. They should not refer all such cases. Many should be handled in the general practitioner's office.

(7) What is the importance of a teaching program? It is recognized that the best hospital care is found where teaching is going on. All psychiatric hospitals should be near medical schools and should have an active teaching program. Each hospital would do well to have a teaching position created, and in this position, a doctor with teaching experience, who would correlate all teaching and special studies and clinical research. In the Veterans Administration we are happy to say all the above ideas are incorporated.

(8) Where can we find the people to do the work? The need for more personnel is now an old story. Long-time planning probably will show the need for a greater number of graduates in all the specialty schools. It will call for a much greater relative increase in the teaching of psychiatric principles in medicine, nursing, social work, psychology. It will alter qualitatively the curriculum of all schools, with orientation at least, and basic training often, in principles of psychiatry.

The personnel problem will continue to be acute. It will be economically as well as socially bad to accept every kind of candidate for psychiatric postgraduate training. Therefore selection of candidates will become important. The Veterans Administration has just made a grant for research to discover the kind of doctor who is likely to make good in psychiatry. I predict it will not be long before improved methods of selection will be common to all graduate schools and will extend to undergraduate schools.

The number of psychiatrists needed has been estimated up to 20,000. That means 40,000 psychiatric social workers, and 20,000 clinical psychologists, according to the generally accepted ratio. It may be that this number can be reduced if greater use can be made of other personnel. The reluctance of doctors to turn over therapeutic responsibility must be over-

come to make use of more people. But this point must be made: responsibility for life and death is a serious thing. A mistake may prolong an illness. Failure to diagnose and treat a condition in its early stages frequently means an early death or a life of torment for the sufferer. We believe the solution to most psychiatric disorders is bound up in a combination of organic or physical plus psychological causes, requiring basic knowledge of the entire body-mind machine. Real understanding of complex conditions cannot be obtained without long years of study and considerable experience. College, four years of basic medicine, general internship and several years of postgraduate training go into the making of a psychiatrist.

I believe that we doctors would welcome the sharing of responsibility—all we ask is that the person who wants to take responsibility for an ill individual, know what he is doing, come to his task well prepared, and be willing to pay the same price that doctors have to pay in terms of training, experience, and judgment. All professional people must pull together. We must do away with misunderstanding and jealousy and fit into the role in which we as individuals belong. I am sure there is no place where mental health is more needed than among professional workers among mental patients. Let us apply mental hygiene to ourselves for the benefit of the patient.

(4) With 19½ million veterans in mind, I ask, what will keep these men and women well? Much less is known about prevention than about therapy. The sick and helpless have a special place in our hearts and much of life's satisfaction comes from aiding others. But we are prone to yield to pressure, exhaust ourselves with the emergency and do little about preventing illness in those who are mentally healthy, and who are beginning life.

In the past, child guidance clinics have constituted the major effort in prevention. These are making great contributions, but there are so few of them, I doubt if they affect the national picture at all.

Meeting the patient before he gets to the hospital—that is, treating a condition in a mental hygiene clinic while still in its milder stages, is a well accepted method of preventive psychiatry. Mental hygiene clincs are most suitable for psychoneuroses which should never be hospitalized in a mental hospital—and only when serious in a general hospital. We are setting them up and they will be good examples of teamwork in the best sense. The big increase in such clinics which we expect to come from grants in aid to states and medical institutions from the Pepper-Priest Bill, will be a great addition to this form of preventive psychiatry. It is important that scientific checks be made on results in these clinics to see what they really accomplish. For our part, the success or failure of clinic

work on veterans will be judged by the success or failure in reducing the number of hospital beds that have been estimated from past experience, and in reducing the number getting compensation for illness.

(10) What is the relation of education to mental health? A good mental hygiene environment is obviously beneficial to children and efforts are being made to create this in all schools. Homes are breeding places of either happiness or harm. Parents, especially mothers, teachers, employers, foremen, personnel workers, all in charge of other people, need special knowledge to handle their charges. In these, education in mental health principles has to sift through an intermediary to reach the person needing help and direction.

We know that information and insight are of value to a person after he becomes ill. Much of a psychiatrist's time is spent in what is called re-education. What about giving all people, as part of their education, some personal knowledge of mental health principles . . . and adding psychophysiology to physiology; adding mental hygiene to classes in hygiene. I believe this to be a useful field to work—but there are many who are pessimistic. They say to understand the nature of fear does not remove a danger. There are many of us who believe that understanding the nature of fear will reduce the fear, prevent it from being repressed, and often keep normal fear from changing into neurotic anxiety.

It may be that one of the most fruitful elements in preventive psychiatry may be found in clinical psychology. Better methods of diagnosis; to supplement experience; more understanding of personality makeup in normal and abnormal; and better methods for evaluating results of therapeutic methods are all available from the field of clinical psychology.

Prevention of mental diseases—achievement of mental health for an entire nation calls for the greatest possible effort, and coordination of all possible sources of aid. We must somehow marshall the energies, imagination and cooperative effort of all groups of society. Man does not live by bread alone—he must have a good inheritance, freedom from disease, contentment, opportunity, freedom of expression, a degree of emotional satisfaction, some outlet for instinctive drives, a chance to grow and expand, some form of security, and a relationship with the Supreme Power of this universe.

Man does not live by bread alone—but he must have bread or he will die. Bread includes roofs, and dollars, and clothes, and some assurance that these will be available for minimum requirements.

The state of the country will determine much of the successes and frustrations of its citizens. This is a tremendous force in adding to or reducing the burden of living. Socio-economic laws are complex and baffling, but we must take all these things into consideration in national planning.

SOME NOTES ON THE PRIVATE PRACTICE OF PSYCHIATRY

By SOL WIENER GINSBURG, M.D.†

It is extraordinary how little attention has been paid in the literature to the private practice of psychiatry by those who engage in it. The work of clinics, hospitals, research institutes, mental hygiene societies, etc., are all more or less adequately presented but a single paper* represents the whole of recent literature devoted to the problems of private practice, as far as I can discover.

The psychiatrist engaged in private practice has a unique opportunity to help inform the public and especially to help undo the many misconceptions of psychiatry now widespread among the laity and which come to his attention almost routinely. A fruitful relationship with the families and friends of his patients, as well as a demonstration in kind of the proper utilization and limitations of psychiatry can enrich the knowledge and awareness of very considerable and important segments of the population. As part of the wide educational program with which we are now attempting to mobilize all our resources, it seems opportune to direct some attention to this hitherto quite neglected aspect of psychiatry.

In good measure this communication deals with my personal experience and a word of explanation is indicated. Mine is an averagely active practice, devoted largely to intensive psychoanalytic psychotherapy and to consultative practice. In the five months from January to May of 1946, I carried from six to nine patients in more or less intensive treatment situations and saw in that time ninety-six new patients. It is on this fairly small but I think representative experience that this paper is based.

Of this number I saw seventy-one on but a single occasion; the remainder from two to five times before suitable disposition was made. They were referred to me for the most part by colleagues; five by social agencies; two by the Veterans' Service Center; eleven by old patients and four by lawyers.

Attitudes toward Referral to a Psychiatrist

Of the patients referred by internists, the degree of their understanding and their acceptance of the referral reflects, in the first place, the care and skill devoted to an explanation of its purpose by the physician. It so happens that many of my patients are sent to me by colleagues whose understanding of the nature of psychiatric consultation is better than average and whose knowledge is more than usually sophisticated. The

† New York, N. Y.

* Muncie, Wendell, Observations on the Private Practice of Psychiatry, *American Journal of Psychiatry*, 102: 111, July 1945.

patients referred by these men have practically without exception an excellent understanding of the purpose for which they have been referred and, in general terms, what they may hope to gain from the consultation.

On the other hand, I see patients referred in an entirely offhand way who arrive with little information as to the purpose of the consultation or who have been persuaded to come to me as a "nerve specialist" and have been "reassured" (sic) that I was not a psychiatrist.

In all the years of my practice I can reckon on one hand the instances where that strategem has succeeded. I urge all colleagues who consult me in advance about using this device to avoid it and to spend more time with the patient preparing him for consultation. An obvious exception to this is in the case of psychotics seen essentially for decision as to suitable hospitalization. Practically all patients are now sufficiently "educated," if only by the movies, to recognize a psychiatrist's office and thus see through the falsehood at once. A doctor recently referred an adolescent girl to me, nominally for "educational guidance," as she had refused to go to a psychiatrist. She walked into the office, took one quick look around, said haughtily, "Oh, Lady in the Dark stuff," and exited without further ado. Subsequently, a wise pediatrician spent considerable time with her discussing her problems; she finally consented to seek treatment, only requesting that she be sent to a woman psychiatrist and is now in analytic treatment with every prospect of cure.

In all fairness to the physician, it must be emphasized that as far as I can see, each time he ventures a referral to a psychiatrist, he risks ensuing hostility not only on the patient's part but by the family as well and not infrequently a loss of both patient and family from his practice. It is not enough for us psychiatrists to be superior and condescending about this, hewing (for others) to a quite unreal, theoretically ideal concept. Nor is it by any means only matters of economics that deter a physician from making a suitable referral in proper time.

We still have a tremendous job to do in educating patients and doctors in the nature of our work and its meaning and true potentialities. My experience underscores the fact that mental and emotional illness still stand in the position that tuberculosis did not so long ago, to be assiduously hidden and denied until recognition and care can no longer be postponed.*

* The last patient included in this series is a 43 year old woman who had a moderately severe depression. For months she was treated at home largely with sedation and hormone therapy and by several physicians, each of whom in turn recommended that a psychiatrist be consulted. Because a daughter was about to become engaged to be married, the family consistently refused out of fear that the prospective groom might be frightened off from marriage. The woman finally made a serious suicidal attempt. It was the prospective son-in-law who arranged for the consultation, and, drawing on his experience as a GI, reassured the family about psychiatry and the hopefulness of its ministrations!

Time and again a physician persuades a patient to consult a psychiatrist only to have the patient return disappointed and confused by the difficulty in arranging even for a consultation. A colleague-friend told me recently that one of his patients called twenty-two psychoanalysts on a list he had given her before she could find one who would accept her for treatment. Another friend (an internist, exceedingly well prepared to make proper referrals) told me he has practically discontinued referring patients to psychiatrists. "I spend much valuable time explaining to the patient the necessity for seeing a psychiatrist; I spend more time finding a suitable person, only then to have the patient return and tell me, "Dr. X has no time and suggested I wait or go to Dr. Y and you'd told me Dr. X was a very fine therapist and didn't mention Dr. Y, and now what?' " "More often than not," continues my friend, "Dr. Y, now 'sold' to my patient, turns out also not to have time and so on, until the patient and I give up in disgust while I return to what I know to be inadequate, incomplete placebo therapy."

The now quite routine procedure whereby one psychotherapist refers a patient to another therapist for reasons of time and/or the inability of the patient to pay the required fee is a matter not easily understood and accepted by our medical colleagues and certainly not by most patients. In general, I find only a beginning acceptance of the time limitations in psychiatric practice and the impossibility of "squeezing" an extra patient into a day already fully occupied. Only recently a sincere and generally well informed colleague, disappointed in his quest for a proper therapist for a patient, asked me to explain why we felt we had to give forty-five or fifty minutes to a patient session. "Granted that is the ideal, shouldn't you psychiatrists of all people be more flexible and, in the face of current shortages, try to see more patients for less time? And, incidentally, at a smaller fee?"

Certainly all of us have now discovered the possibility of doing excellent therapy without seeing a patient five or six times a week. Without any formalized concept of "brief" therapy, the exigencies of the situation forced us to see patients once or twice a week and, although many of us had been doing just this in hospital clinics for years (and for only twenty to thirty minute sessions!), it came almost as a shock to realize how well it worked in one's office.

I have had no personal experience with group therapy and I am still not persuaded about its usefulness in civilian practice. It is very difficult for me to grasp how it might work in private practice and I await eagerly the experience of more venturesome colleagues who are now undertaking group practice in their offices.

The matter of fees is a highly individual one and, as medicine is now practiced, a matter of personal needs and attitudes. To judge from my own

experience in New York City today, because of the expense, adequate psychiatric care is available only to a small percentage of those who want it. Of the ninety-six patients here reported, I thought fifty needed more or less intensive psychotherapy. Of these, twenty could afford with more or less difficulty as full a program as I suggested; sixteen could afford "something," usually much less than seemed desirable. Fourteen could afford so little over a period of time that it would have been wiser and fairer to have referred them to a clinic. Often, however, they earned too much (all things being relative!) to be eligible for a clinic.

In addition, there is a great dearth of clinic facilities, especially those which accept referrals from sources outside the hospitals to which they are attached. There are also geographical restrictions which make clinic referrals difficult. And what is perhaps most serious is the fact that with very few and as yet insignificant exceptions, the psychiatric clinics meet during the day, often requiring loss of pay and at times simply precluding clinic attendance for a working person.

The factor of time mitigates against the easy acceptance of psychotherapy even among those who can afford the expense. Men and women who work can seldom afford the ninety to one hundred minutes of a working day that a visit in New York City requires. Relatively few people can regulate their working day to include so long an absence with any frequency and regularity.

Of course there are other and more profound factors involved in this phenomenon. Unconscious factors of resistance; too long antecedent therapy on an organic, pharmacological basis and plain ignorance are all variously involved.*

One factor that makes for much difficulty is the fact that many physicians simply do not know which patients to refer—and this applies in the direction of over-optimism as well as skepticism. As long as medical education is so deficient in its teaching of psychiatry, we must expect this condition to continue.

For instance, to give but a single example, most physicians with whom I have dealings still believe the equation "neurotic = curable; psychotic = incurable" and it is very difficult for them to accept that a neurotic process may be entirely irreversible and untreatable and that not every psychotic need be continuously institutionalized.

* In this connection, the report of a study done under the auspices of the New York City Committee on Mental Hygiene of the State Charities Aid Society on "The Needs for Psychiatric Care among Neuropsychiatric Rejectees and Dischargees" is significant. In the sample we studied, eighty-one per cent of the men were thought to need some form of psychiatric assistance but only about twenty-five per cent of this number were able to admit their need and seek help. The report discusses the problem at length and will soon be available.

I see a fair number of patients (seven in this series) who need psychotherapy and who live forty to two hundred miles from New York City. For them the problem is even more difficult as few of these neighboring towns have any psychiatric help available. It is encouraging to be able to report that some psychiatrists returning from service are wisely settling in these nearby places.

Patients' Attitudes to Psychiatry

In recent years and especially since the first glowing reports of psychiatry in the armed forces began to appear, a new phenomenon presents itself daily. There is no question that we have now oversold certain aspects of psychiatry; patients of little education and knowledge ask with quite some assumed sophistication about hypnoanalysis, narcosynthesis and especially shock therapy. Time and again I see patients with mild depressions, for instance, and indicate the usual simple therapeutic devices that so often suffice in these cases, only to have the patient, the family and/or the referring physician demur because I have not suggested shock therapy.

It so happens that my personal experience with shock therapy has been quite disappointing and while I am impressed by the optimistic reports in the literature, I do not find the results duplicated either in patients I refer for such treatment or in those who obtain it without my approval and of whose course I subsequently learn. I view the use of shock therapy in ambulatory patients with many reservations, especially since it is now often given at the request of those entirely unqualified to decide as to its suitability. I might mention, in passing, that of this group of patients, five had shock therapy, with some improvement in two. My own overall experience has been even less satisfactory.

It is most difficult in private practice to persuade families and doctors, much less the patient himself, that shock therapy should practically always be considered only as *part* of treatment and not its entirety, and that some attempt at psychotherapy is, in many cases, a more vital part of the therapeutic regime.

Hospitalization of Patients

Ten of this group of patients were hospitalized in four different hospitals; two patients going to state institutions,* the others to private hospitals.

* In the last few weeks since the appearance of a series of "exposures" of conditions in mental hospitals, I have suggested hospitalization for three patients whose circumstances required their referral to state institutions. In all three cases it was flatly refused on the basis of what they had read. Whatever the merits of this type of publicity, the effect on patients and their families is not to be overlooked in the quest for reform from the outside. If psychiatry were more vigilant and aggressive in protecting the needs of mental patients, it would not be necessary to resort to this sort of propaganda.

The psychiatrist who refers his patient to a private hospital with which he is not connected (and very few psychiatrists in New York City serve on staffs of psychiatric hospitals to which they can refer private patients) receives a reception varying, in my own experience, from the utmost friendliness to calloused discourtesy. But, whatever the personal unpleasantness may or may not be, he surrenders all but a purely verbal participation in the care of the patient. I realize how this almost inevitably occurs in hospitals with full time staffs which assume full responsibility for the care of patients accepted by them; it remains, however, a serious drawback on two scores. In the first place, one cannot treat or even supervise the treatment of one's own patients; secondly, it is very difficult for the average layman, accustomed to ordinary medical and surgical practice, to understand how a psychiatrist, who has usually been built up in his mind by the referring physician as a person of repute in the community, must surrender all control of the patient brought to him for care. As Muncie pointed out in his recent paper,* this usually leads to the hospitalization of patients in unsuitable institutions where the doctor does have "privileges" or to the continuing ambulatory care of patients who could be more adequately treated in a suitable hospital.

The average cost of care in a proper mental hospital ranges from sixty-five dollars per week upward, a cost far beyond the means of the average middle class family, especially when one considers the usual duration of the hospitalization. Many cases are treated on an ambulatory basis where the psychiatrist recognizes the need for hospital care but where hospitalization in a state institution is refused and private care economically impossible. In addition, I find in practice the persistence of the most archaic notions about psychiatric hospitals. The legend of stigmatization is especially hard to defeat and much more reeducation is obviously needed to correct such impressions.

On Service People Seen in Practice

In this group of patients seven were recently discharged and two were still in service. Only one of the seven veterans had been a patient in a service psychiatric installation and, although he was a seriously disturbed hysteric, he too had been discharged on points. He succeeded in denying his symptoms long enough to be returned to duty and home, so great was his feeling of dread that he might be further labelled a "psycho."

The other six patients all had had fairly long and successful service records, only to develop symptoms requiring care on discharge. Interestingly enough, one of them was a man I had seen ten years ago on one occasion because of difficulty at school. His Rorschach at that time re-

* Muncie, *op. cit.*

vealed a severe hysterical pattern. He had had no therapy; his Army record is one of unusual brilliance. Only on his return to his home where he again came under the influence of hostile attitudes, parental and otherwise, did his symptoms reappear. The syndrome of homecoming "jitters" and depression is now a familiar one. It is fascinating to speculate on the psychopathology which permits a man to go through four years of untold hardship and danger without a day's sickness, only to be depressed and miserable, irritable and fractious when "safe" at home again.

The following table summarizes the diagnoses* in these 96 patients.

Psychoses	
Schizophrenia	13
Manic Depressive Psychoses	
Depressed	4
Manic	1
Reactive Depression	3
Involutional Melancholia	1
Paranoia	3
Senile Psychosis	2
Post-partum psychoses	3
Psychoneuroses	
Anxiety neurosis	7
Obsessional neurosis	7
Anxiety Hysteria	5
Conversion Hysteria	5
Mixed Neurosis	5
"Character Neurosis"	3
Neurotic Depressions	3
Psychosomatic Problems	
"Anorexia Nervosa"	2
Anginal Pains	1
Hypertension	1
Healed pulmonary tuberculosis with continuing symptoms	1
Ulcerative colitis	1
Consultations concerning members of the family	8
Marital problems	6
Alcoholism	5
School problems	5
Consultations concerning employability of person	1

I do not wish to extend this paper to a clinical discussion of the material. I would comment merely on one fact. Increasingly, I find people referred to me for preclinical problems, so to speak. Marital tensions not yet serious but threatening difficulties; business problems reflecting neurotic difficulties; school failures recognized early and not explicable on the basis of poor intelligence; personnel problems; and other similar situations. In some of these we can offer a most gratifying service and I believe this is a field which justifies much more investigation.

The psychiatrist in situations such as this should be a bit of a friend, healer, practitioner and scientist; the adequate management of such situations requires an ability to tread lightly and yet deal forthrightly with immensely complicated problems.

It is a frightening fact to note how many of one's patients have been long treated for difficulties entirely unrecognized as emotional until they

* These are simple "working diagnoses" and make no pretense to scientific accuracy.

finally find their way to a perceptive physician. Of the ninety-six cases here reviewed, thirty had been seen by three or more physicians before reaching the referring doctor. I have no way of knowing, of course, how many of them recognized the psychiatric aspects of the problem. Suffice it to say that, whatever the reason, there had been no approach to these elements in the case.

Conclusion

The psychiatrist in private practice has a wonderful opportunity to do an important educational job with both physician and laity. It is important that we do not overlook it in our preoccupation with the more directly clinical aspects of our practice. Although the care of the patient must naturally always be our primary consideration, we should try to remember that in turn each new patient affords us a contact which can be suitably utilized to inform and educate a group in the community. In the aggregate of our efforts, I believe this can be of immense value.

MODERN CONCEPTS OF WAR NEUROSES*

By BRIGADIER GENERAL WILLIAM C. MENNINGER, M.C., A.U.S.

As a conservative estimate, there are at least a million more people in this country tonight than there were three years ago, who have heard of, have dealt with, or are personally concerned with that medical entity called psychoneurosis. Many millions more are familiar with pseudonyms for this illness—operational fatigue, combat fatigue, combat exhaustion. From the language of the G. I., one could add more terms descriptive of neurotic reactions such as gang plank jitters, slap happy, bomb happy, reple deple exhaustion, etc. We in medicine are confronted with the fact that the membership of the military and their families at home have become increasingly educated on this subject, for better or worse, during the last three years. It is now a paramount responsibility of the medical profession, not only to correct much of the misinformation that exists, but far more important, to understand and effectively treat this illness. There are many former soldiers among the three hundred thousand odd veterans who have been discharged from the Army because of this illness who will need medical help.

There is a certain incongruity in the fact that it was the war which directed such a bright spotlight onto neurotic illness. Certainly no medical condition which occurs in civilian life can compare in incidence with the psychoneurotic problem, the origin of which lies in the conflicts caused by the pressure of everyday activity, the competitive nature of economic and social life. About fifty per cent of all who go to a physician present primarily emotional difficulties that correctly classified are some type of psychoneurotic reaction to the problems in their lives. With this civilian background, it is not surprising that the strenuous existence of the Army precipitates further neurotic expressions. Thus, life in the Armed Forces focused conspicuous attention on this characteristic of the American people.

Even more significant than the large number of individuals who are diagnosed by the doctor as psychoneurotic, is that sizeable segment of the populace which makes a difficult adjustment to life, though never develops a neurosis. They manage to get along reasonably well only because of some sort of support, some special indulgence, some particular type of relationship. There are many variations in such adjustments—the husband who lets his wife assume the masculine role, the wife who plays this role, the joiner and the hermit, the braggart and the gossiper, the daredevil and

* Given Oct. 8, 1945, as the Ludwig Kast Lecture, before the 18th Graduate Fortnight of the New York Academy of Medicine. Reprinted by permission from the Bulletin of the N. Y. Academy of Medicine, 22: 7–22, January, 1945.

the timid soul. They are the objects of our observation and comments in the closed circle of friends and family. They are not patients of any doctor and may be productive members of the community. They are, nevertheless, neurotic. We, those of us with any psychiatric insight, should not fail to appreciate that all the rest of us make use of neurotic defenses to some degree; always when under special stress of the environment and often when the stress is entirely internal.

With the psychoneuroses and the neurotic adjustment reactions, psychiatry is familiar. The growth in our knowledge of the understanding of the anatomy and the physiology of the personality has given us a reasonably clear picture of the mechanisms behind such relationships and behavior. It is the consensus of the great majority of the psychiatrists in the Army and the Navy, that the same mechanisms are operative in the military and that the same clinical pictures occur as we see in civilian life. Essentially, the response is the same when John Smith cannot adjust himself to the family at home or the artificially created family situation in the Army; when Paul Jones cannot stand the tempo of the factory and is unable to stand that of the Army.

There is, however, a group of reactions in the Army which does deserve special consideration because of certain features in the dynamics of its development that are characteristic. There are personality disorders occurring in the course of combat which, though not new, are at least different from those customarily seen in civilian psychiatric practice. It is this limited field to which I shall devote my attention.

Background for Understanding Combat Exhaustion

A prerequisite for understanding either pathological processes or pathological states is a knowledge of the normal. This entails not only anatomy but physiology and applies to the psyche as well as to the soma. In spite of the difficulty of condensing such an explanation into the time allotted here, it seems desirable to set forth certain fundamental facts regarding the personality and its functioning that are well known to dynamically oriented psychiatrists, in view of the fact that the main point of this discussion is psychopathology.

A child is born, as any other quadruped, primitive, cannibalistic, asocial and uninhibited. The personality at birth is endowed with the two recognized fundamental drives of aggressiveness and erotism, perhaps more broadly described as destructive and constructive urges, as hostility and love. With growth and training the personality develops its individuality with a conscious regulating portion which becomes the ego. The child learns to curb his instinctive infantile behavior through the training and supervision of his parents. Initially all restraint is exercised by these ex-

ternal powers. The child learns to control his aggression and is rewarded with love. Beginning in his early childhood, he unconsciously incorporates this control function within himself and psychologically includes this function of his parents within his own personality as his conscience.

When the personality is mature, failure on the part of the ego to control the aggressive impulse is always accompanied by anxiety. Consequently anxiety comes to be a signal of disturbance within the personality. The impulse acts as a threat to the security of the ego which has from experience the foreknowledge of the disapproval from the conscience. The picture becomes complicated when there is, in addition to the internal threat, an external threat in the form of danger. Psychiatrically, it may or may not be rather simple to differentiate anxiety which arises because of a disturbance within the personality from the apprehension or fear that arises from the external situation. Thus, the compulsive individual often may manifest anxiety without any external danger or threat. In some instances, we see great apprehension or fear due entirely to external danger which superficially may resemble anxiety. Or they may be combined, as in the case of the combat soldier.

Thus in a very over-simplified condensation of the dynamics of anxiety, we see that its origin is the unconscious aggressive impulses which threaten the ego which if it fails to control them is criticized by the conscience. The conscience also becomes of special significance to the combat soldier, in that its critical faculties of certain behavior are relaxed and its individual idealism or code is, to some degree, displaced by the group code. Its development, and in fact the development of the total personality, is subject to many variations with numerous potent influential factors.

The relationships of the soldier with his father and with his siblings may both greatly influence his acceptance of his military role. Ideally the child likens himself to his father, following an initial and important struggle in his orientation toward authority. When this identification has been relatively smooth, the son accepts the role of submission to this father authority, becomes dependent upon him and borrows psychological strength from the process. Where the ideal role has varied and the son has developed no identification, where he has continued to resent the father and his authority, one must expect difficulty in all subsequent situations where the individual must be subservient to a father figure. This has frequently been encountered in the adjustment of the soldier to his leader and is of special significance for the man in combat. Except as eccentric daredevils, such soldiers are a liability in combat, but only a small minority fall in this category. The great majority transfer their original unconscious relationship toward the father to their commanding officer.

Further complications in the development of the personality are of

special importance in some soldiers. Even in ideal maturity, recognized unconscious patterns of reaction exist between siblings. Associated with these are positive and negative feelings of affection and hostility. In the soldier's situation, the buddy may unconsciously come to represent a particular sibling and his reactions are, to some degree, predetermined by his relations to his true sibling. Sometimes there is a strong attachment with minimal negative feelings and sometimes a strong attachment despite strong negative feelings. Army life in itself is often conducive to very strong attachments between men. They share training, experiences and dangers. When one is wounded or killed, such experiences alone may explain much of the reaction. On the other hand, where a previous sibling relationship existed in which there was unconscious hostility, this may be the chief determining factor in the symptomatology of a breakdown. One must postulate that in all cases, the early family relationships condition the soldier's behavior toward his associates.

One must not ignore other factors operative during the formative period which have also influenced the pattern of the soldier's personality. These make up the total social environment in which he grew up to function as an individual. Civilization represents an extension of the original parental influence as a curb of the primitive man, which aims toward social maturity of his group. For the soldiers in this war, there were many special national problems and attitudes present which directly influenced their childhood and adolescence. Some of these were parental unemployment, the struggle of democracy versus dictatorship, an isolationism in attitudes of our people toward the rest of the world. There were the good and the bad effects of radio, screen and transportation speed which developed concurrently with the soldiers of this war.

In addition, the tradition of the American culture is to produce a personality with emphasis on individualism and independence. Deeply ingrained self-respect and a high degree of self-determinism were American characteristics and these were coupled with a free and unrestricted privilege of self-expression. Such were the influences to which the personalities of our soldiers were subject.

New Environmental Stresses in Becoming a Soldier

Pearl Harbor caught us unprepared to aggressively express ourselves in war against another nation. In contrast to the belabored debate of the months preceding, as to whether or not the show in Europe was any affair of ours, the psychological effect of Pearl Harbor on the nation was to cement us into a singularly unified attitude. Unfortunately, before many months had passed, that unanimity of opinion and determination of purpose became somewhat decimated and vague. At the same time, men were

regularly and speedily taken into the Army in large numbers. What was their motivation as they joined the Army? One has to conclude that in a great majority of instances these men, being law-abiding citizens, came in because it was the will of the country. Not a few had a resigned attitude, and undoubtedly the lack of emotional tone in the populace at large led many to feel that fate had played them a poor game. They went because it was their duty, but rarely with enthusiasm or conviction.

When the man became a soldier, there were changes in his external situation which demanded major readjustment. He gave up his normal gratifications almost entirely. He had to accept separation from his family, his home, his job, his friends, with little in prospect except the possibility of adventure. He had to give up his individual identity and become a member on a team, with the only reward being his identification with that team. He had to accept severe privations in return for very restricted gratification.

For that group of men who had to go into combat, there was another series of adjustments required, those for which there is no parallel in kind or degree in civilian life. The personal danger surrounding the combat soldier made all other adjustments pale into relative insignificance. The necessity of throwing over all previous ideals, not only of his own conscience but of the group conscience to accept the requisite of killing to avoid being killed was a greater change than many people realize. Frustration was a daily part of his life, sometimes in the form of waiting—days, weeks, months; sometimes in the deprivation of essential supplies. Confusion was routine in his life and the noise and whistles and flares of battle are beyond the imagination of anyone who has not heard and seen them. Insecurity was constant, not only in his personal doubts of himself, but also the doubts regarding his orders, doubts about the leader's ability, and knowledge, doubts as to whether the higher-ups understood and would act, or permit him to act. In addition to all this, was the extreme physical discomfort, the loss of companions, the ever present pain and death.

All of these factors operated on the personality and it is amazing that so many American men tolerated them so effectively. There were comparatively few compensations, few supports against all these pressures. But without question it was these supports that enabled them to function. Probably the most important of them was the leadership of the unit. Psychologically the leader is well recognized as representing the strong father figure who is interested in the individual, who is looking out for him, who is considering him, who knows what he can do and actually leads him. Nearly as important as the leadership, however, was the group identification, the esprit de corps created by close association, the common aim and mutual sacrifice. Many soldiers freely admitted that it

was chiefly because of their feelings of loyalty and devotion to their associates that enabled them to go on. Their individual civilian-life conscience was displaced by a group conscience, which served both in a positive and negative fashion. Positively it gave them permission to kill, a behavior antithetical to their entire life ethics and training. Only through group permission and approval could they do it and even then it was often very difficult. The group conscience supported them in a negative way—it prevented them from quitting because of the fear of group disapproval. The close personal attachment to and dependence of a soldier on one or more members of his group, his buddies, was a very important force in maintaining his combat ability.

Other definite aids to the withstanding of the external stresses of combat were the soldier's training in discipline and obedience and along with it the confidence in his own ability and in his weapons which was developed through such training. He was sustained by his own physiological responses, the result of stimulation by excitement of the autonomic nervous system which enabled him to be aggressive. A minor, but in some instances an important reënforcement, was the glorification of the mission in which he was partaking, a glorification which in the extreme made even death seem a little less unattractive; at least he faced the prospect of a hero's death.

Psychological Changes in a Soldier to Meet These External Changes

While one may enumerate the various supports and compensations which helped make a soldier able to face combat, they alone were not enough. Less apparent dynamic changes in the personality were necessary to effect adjustment. It is important to recognize that in the majority of instances these changes are unconscious and therefore automatic, but without a doubt must occur for the individual to effectively meet the demands made upon him. The first of these is to change from his civilian independence with initiative and self-expression to a dependent role of submission to leadership orders and group requirements. Granted that the soldier has an opportunity, in a limited degree, to develop his individuality in certain isolated instances, the winning of a battle demands that the good soldier rely on his superior, and that he accept and carry out his superior's orders promptly and exactly. He must therefore accept a predominately dependent emotional role. This acceptance, while difficult for some, is welcomed by others. In any event this change may bring unconscious satisfaction in that it requires the man to shed responsibility, to live on the decisions of others, to have his daily life planned, to passively be the recipient of his food, his clothing, his shelter, such as it is.

This passive relationship grows more rapidly and becomes acceptable when the soldier feels secure through his confidence in the symbolically

all-knowing, all-powerful father, his commanding officer. Subservient to this officer and under his direction he learns to modify a lifelong constructive drive in order to allow the functioning of a primitive, destructive one. Only with this help can the average man shift from a constructive civilian life to a chiefly destructive soldier life. Even so, the change is so difficult that severe psychological problems arise.

Many soldiers never had to make the psychological adjustment to the process of actual killing and seeing the result of their aggression. The bombardiers, the artillerymen rarely, if ever, saw the result of their work at close hand. In contrast, the infantry soldier often, if not regularly, was in a position to observe his effectiveness. Because of this there were many instances when soldiers who could not bring themselves to kill, even under the pressure of facing leader and group censorship, became ill from the psychological conflict involved. In other instances, a soldier might reach a saturation point, a limit to his ability "to take it"—referring specifically to his necessity to kill.

Other factors come in play in those occasional situations where hand to hand combat takes place. There the imminent external threat is sufficient to overcome the influences of the conscience, even in those who under less threatening circumstances found difficulty in killing.

Another dynamic change in the functioning of the soldier's personality is the necessity to shift his investment of affection from individuals to a group. Throughout his life he has had a fixed and more or less constant association with certain individuals—mother, father, siblings, wife, children, long-time friends, with whom he has shared love and interest. They have been, quite literally, his world. These he must temporarily set aside and from them he must shift, for his immediate investment of affection and return of interest, to a strange heterogeneous group of men, to a diffuse group love in contrast to his previously specific individual love. Certain members of the unit gradually become his inner circle, and maybe his chief support, but the major identification for an effective unit must be made with the group and he must fuse himself with it.

This review of the dynamic forces in the life of the soldier about to go into conflict indicates that he must accept an emotional regression to an earlier developmental stage in order to permit his acceptance of the essential dependent passive role. This does not imply that he must make an intellectual regression or that the whole procedure is accomplished with considerable insight. It is nonetheless through such regressions that he can mobilize and express the primitive aggressive drive present in everyone of us which is essential to the functioning of a fighting man. This regression in no sense lessens his need to protect himself and undoubtedly the external threat is a major stimulus to the expression of this aggressive drive.

It is through the full approval of the good (father) leader that the dictates of the individual and personal conscience can be ignored. If either the leader or the group approval is not constant, the soldier's main psychological support is lost. Consequently, we must recognize that the soldier, even before he starts combat, is in the predicament that not only is he faced with an extremely dangerous external threat but with a potential internal threat.

The Development of a Neuropsychiatric Reaction in Combat

One must see the combat casualties in this stage setting. In general, there are two large groups of reactions with no sharp dividing line: first, those individuals who are grossly predisposed to maladjustment, and second, those with minor or no apparent predisposition. In the first group, the combat casualty presents a familiar neurotic response, similar to the picture seen in civilian life. Even though the soldier had succeeded in making a passable adjustment to all his pre-combat training, the stress, and usually some specific feature of combat—upset the balance of his equilibrium. Such patients initially present typically neurotic defenses—conversions, obsessions, psychosomatic complaints, etc.

In both of these groups one may observe various devices used to protect the individual against his anxiety. Many soldiers adopted a fatalistic attitude expressed in the remark, "one of them has my number on it and when it comes, it comes." The utilization of omens, charms was common. These all represented a magic protection of the ego and were common to all soldiers. One could discern cumulative effects of various events although the anxiety is controlled. With increasing fatigue, one might often note a slight impairment of the individual's judgment, his tendency to carry out repetitive activity, such as jumping in a fox hole without adequate testing of the reality situation. Such automatic responses were even active in places of relative safety. In many instances a narrow escape, the death of a platoon member were contributory. A very common observation was the case of a wounded man who only began to develop anxiety as his wound healed and he was confronted with a return to combat duty.

A second group of soldiers, certainly the majority, appear, at least superficially, to be normal personalities reacting to abnormal stress. They give no history of previous maladjustment in civilian life, no history of distress to themselves or their family. However, these soldiers must have some predisposition, minor though it may be. Undoubtedly, the outcome of their reaction to combat depends on the degree of this predisposition. It is gratifying to know that the majority, probably the great majority, responded sufficiently under appropriate treatment to permit them to

carry on. That their experience leaves scars, there is no doubt, but certainly in many, these scars are not sufficient to seriously or permanently disable them. Our figures indicated that sixty per cent of the psychiatric casualties from combat were able to return again to service in the Army area, and at least fifty per cent of these, in certain instances more, returned to actual fighting. We should have no illusions, however, about this group. The Army medical officer's function was to return the soldier to duty. Neuropsychiatric casualties, if adequately rehabilitated, were no less expendable than rehabilitated surgical casualties. If they were well enough to do further duty, that was their assignment, and many carried on indefinitely. The permanent effect of the Army experience, and specifically that of combat, on their personalities will only be known with the passage of time.

There is also a group of men, in whom the predisposition, even though not apparent on the surface, was serious enough so that they did not respond quickly to treatment. An additional larger number showed a delayed reaction; they completed their tour of duty and only then, under different circumstances, perhaps as they returned home, did their psychological battle scars manifest themselves. In every instance of these delayed reactions, there is very good evidence to believe that there was a specificity for the individual in the final event or situation which served as the precipitating factor.

Grinker and his co-workers very adequately describe the various types of regressive pictures based on their chief symptomatic expressions under the groups of passive dependency, psychosomatic reactions, guilt and depressive reactions, aggressive and hostile reactions and psychotic-like states.

The immediate clinical picture was colored far more by the combat situation than by the individual's particular personality. This was as true of the man who broke down in the first few days as of the man who broke after many months of combat. Their clinical pictures were remarkably similar. From a psychological point of view, such reactions were the result of cumulative stress. In both cases the man had reached his limit as a result of physical fatigue, the continuous threat to life, the single or repeated psychological traumata, all of which had exceeded his capacity to handle.

The clinical picture has been described by several combat experienced psychiatrists. The prodromal symptoms are most frequently irritability and disturbance of sleep. The individual is aware of his increased sensitivity, his "startle reaction," his involuntary self-protective motor responses to sudden noises. Sleep becomes disturbed because of sudden involuntary starting or leaping up because of noise stimuli or disturbing dreams. The soldier himself may recognize his symptoms or the man's

behavior or change in personality becomes apparent to those about him. He may become more seclusive and silent, or on the contrary, more talkative; he may be restless, may smoke excessively if the opportunity permits. He is aware of an increased apprehensiveness but paradoxically is less able to concentrate. He frequently shows somatic symptoms such as mild tremor, incontinence of urine or feces.

There was a monotony in both the complaints and the symptoms as seen by the physician in the aid station or by the psychiatrist at the clearing station. The complaints differed depending upon the stage of personality disorganization; in the majority of cases they followed a stereotyped pattern: "I just can't take it any more," "I can't stand those shells," "I just couldn't control myself." The symptoms varied only slightly from patient to patient. Whether it was the soldier who had experienced his baptism of fire or the older veteran who had just lost his comrades, the superficial result was very similar. Typically he appeared as a dejected, dirty, weary man. His facial expression was one of depression, sometimes tearful. Frequently his hands were trembling or jerking. Occasionally a man would display varying degrees of confusion, perhaps to the extent of being mute or staring into space. Very occasionally he might present classically hysterical symptoms. Some of them knew that they were "combat saturated" and that they might be through so far as fighting was concerned.

Such is the common immediate reaction, one that does not on its early symptomatology fit into any of our known diagnostic categories. For this reason, the widely used terms of combat exhaustion and operational fatigue have probably been very practical for their utilitarian aspect. They have the disadvantage of implying that physical exhaustion or fatigue plays a major role. It no doubt does contribute an influence, varying in different situations, but it was never possible to set up a series of physiologic experiments which might have given some index as to its actual effect. On the basis of broad experience, it has been estimated that not more than 3 to 5 per cent of the reactions were due entirely to fatigue. In the other 95 to 97 per cent the condition was primarily a personality disturbance and was treated as such.

The commission of five civilian psychiatrists who visited the European Theater in April and May of this year were united in their opinion that the picture of psychologic disorganization did not correspond either in its moderate or in its extreme form to any recognized or established psychiatric syndrome. They regarded the term "combat exhaustion" as a practical term to apply to this temporary condition, out of which various more definite and more familiar syndromes evolve. This diagnostic label does not apply beyond the initial state, and as such represents a transient

psychiatric reaction to combat, that may or may not progress to a more clearly defined clinical entity. Consequently, it has no applicability beyond the immediate response. It does not apply to the further evolutionary stages, the typical psychoneuroses, nor does it apply to the delayed symptoms so often seen, those typically regressive phenomena, in men who have completed their tour of duty, which occur at a time when the support of the group and the leader is gone.

Psychodynamics of Combat Exhaustion

The psychodynamics of combat exhaustion include four significant features: the depleted ego strength, the specific precipitating trauma, the mobilized aggression and the loss of the ego supports in the form of leadership and group identification. The depleted ego strength, the ability of the conscious personality is in every case cumulative, regardless of the length of combat. One must assume that certain types of personalities can withstand stress over a longer period of time than others, but the breakdown of the soldier in combat, whether it is during his first week or his fifteenth month, is related to his ability to withstand the stress, plus the avoidance of any specific psychological trauma which would overbalance his ability to adjust to the external demands. However, the cumulative effect is a major factor, so that whenever the specific traumatic event does occur, it may in some cases appear trivial. Just as in civilian psychiatry, though it is often not possible to discern the specific precipitating factor in the production of mental illness, there is much evidence to believe that it is always present. The soldier may or may not be able to describe certain events which may have been the final straw—the death of a comrade, the hopelessness of a particular assignment, a broken promise.

Two factors permitted the soldier to express his aggression. One of these was the external situation, the necessity either to kill or be killed. The other and probably the more significant, in the situations which were less immediately threatening, was the approval and command of the leader and the identity with the group which shared the common aim. When and if these psychological factors suddenly disappeared, one found the dependent ego with a high degree of activated aggression with no outlet to express it. In the very rare situation, the soldier might carry on alone; such were likely to be the winners of Congressional Medals of Honor. Much more often, with the loss of the leader and/or the group, the soldier was at a loss. The combination of his helplessness and his activated aggression invariably created anxiety.

It is the ego's normal function to maintain the integrity and equilibrium of the personality against both the external stress and the unconscious forces within the personality. It is helpful to think of the ego as having

a given strength, of a strong or weak ego, of increased or decreased ego strength. In the combat soldier, the continuing effect of combat accumulates and drains the ego's ability to maintain balance. In the specific traumatic event of the final wound, it must attempt to control a powerful aggressive impulse which it can now do with only limited success. Its failure gives rise to anxiety which, if transformed into symptoms, comprises the clinical picture—the irritability, the sensitiveness and jumpiness, the depression, the inability to concentrate or accomplish even relatively simple tasks, the dreams which recur so characteristically in the combat psychoneurotic personality.

In many medical conditions, even the pathology represents an unhealthy attempt to rectify or alleviate the cause of that pathology. This phenomenon is even more pronounced in psychiatry in which the symptoms are, in a sense, an attempt at a solution of a conflict. A special characteristic of some mental symptoms is the tendency to repetition, so brilliantly described by Freud as a repetition compulsion. This process is a conspicuous feature of combat exhaustion and is perhaps best illustrated by frequent similar dreams. The dynamic significance of the dreams, in general, is that they are an effort of the unconscious to resolve the conflict by mobilizing the anxiety to expression. Because the whole dream process is unconscious, the individual is not relieved and may be so disturbed by the dreams that the illness is aggravated. This creates a situation in which the individual is stimulated but is not permitted physical expression, and the more the physical expression is inhibited, the greater becomes the anxiety. Unless there is aid given to bring the conflict and its resolution to the conscious level and into reality, the neurosis continues. What was originally stimulated by an external threat becomes internalized and without help may become an insoluble vicious circle. The unconscious emotional pressure continues to produce anxiety in increasing amounts without conscious recognition of its causes.

Conclusions About the War Neurosis

In summarizing the main features of the war neurosis discussed above, one needs to remind himself that this group of reactions to combat represents only a small percentage of the total psychiatric problem of the Army. It does not include the neurotic reactions occurring in basic training, on boarding ship, in sitting on a lonely south sea island, in weathering a monsoon season in India. Nor does it include the 25 per cent of all types of discharges for psychiatric reasons because of warped character development. All of these groups are familiar to psychiatry and differ in no way from the same pictures in civilians except in the environmental situation in which they developed or became apparent. Very often they were re-

vealed only because of that situation; they might have gone unnoticed in civil life.

Only combat reactions, represent the true war neuroses. They too become apparent only because of the situation. They have been described as the normal response to abnormal situations in which the stress was far more severe than in civilian life. It is reasonable to assume that many men developed these reactions who might well have gone through civilian life without manifesting any gross maladjustment. Furthermore, many who did suffer from such traumatic experience apparently recovered quickly, even to the extent of successfully continuing the same severe test of adjustment.

In summarizing the dynamics of combat breakdowns, there would appear to be a combination of the severe cumulative external stress, a varying degree of predisposition, a peculiar psychological setting in which the combat soldier functions and a specificity of some particular event which precipitates the incapacitating result. Any or all of these may vary in each individual case, some of them being all important in one instance and inconspicuous in another. When the final straw is placed on the soldier's back, the immediate result appears very similar in all cases. Fortunately, with relatively little help the majority promptly readjust. For the remainder, and numerically the group is large, there was and will be need for further psychiatric treatment.

Only as we understand these dynamics can we understand the symptoms which we may see in the veteran patient. His weakened ego cannot handle the aggressive forces which have been activated. His solution is to regress to simpler functioning level. In some cases, instead of returning to his normal adjustment he remains in the regressed stage of development where he can express his passive dependency, his depression, his hostile reactions, his somatic complaints. He cannot explain his symptoms—his feeling of helplessness, his stomach disorder, his irritability and impatience, his tendency to fly off the handle, his failure to find satisfaction, his resentfulness of all but his own group. Some will return to civilian life with a tendency to feel that no one understands and with latent, or expressed, paranoid attitudes. They do return, in a sense, to a foreign atmosphere but their attitudes are not caused so much by this fact as by their personalities which are heavily burdened with the conflicts arising from their battle experience.

With this understanding on the part of the physician, treatment must be directed toward integrating the individual into his pre-war identifications and satisfactions. If he comes with emotional problems, with pent-up resentment which he cannot manage, these must obviously be released. With this release must come insight through psychotherapy, not only into

the immediate situation but into the origin of these emotions in their relation to previously formed personality patterns. What is the treatment and by whom should it be given? No simple set of rules can be laid down but some patients are going to require expert psychiatric care and others can certainly be helped and probably readjusted by the intelligent, sympathetic physician who has some psychiatric orientation. In other words, some patients, to borrow an analogy from surgery, will need major and others minor psychiatric procedures. The former should be carried on by an experienced psychiatrist, the latter could be adequately directed by a general practitioner or a specialist in another field.

One might generalize by saying that if the patient has made an attempt to fit into his civilian situation and is consciously aware of his symptoms, is preoccupied with his traumatic experiences in the Army, has recurring disturbing dreams, the chances are that he should see a psychiatrist. Just what the treatment would be is hardly within the province of this presentation. In the Army, we have found that psychotherapy under sedation is a valuable short-cut to relieve the pent-up emotion. Hypnosis has also proven to be an effective therapeutic tool for this purpose. In both of these types of treatment, the ultimate success depends upon the skill and the knowledge of the psychotherapist.

On the other hand, if the patient is exhibiting minor evidences of anxiety in the form of restlessness, minor physical complaints or problems of adjustment to the people around him, it is very likely that the general practitioner can and should help meet these problems. In so doing, he needs to appreciate that sometimes he can help directly by merely being a good listener and pointing out the inconsistencies, the discrepancies in the man's thinking and feeling processes. Very often he can make positive suggestions with regard to the manipulation of the environment. If one could insure sufficient family affection, economic and social security, easily accessible ego gratifications and good physical health, many of these veterans would be helped if not entirely rehabilitated.

When one takes into consideration the fact that 315,000 soldiers have been discharged from the Army for neuropsychiatric reasons, he may grasp the importance of this problem as a post-war challenge to medicine. A fair percentage of these have had combat experience and will present the dynamics and the clinical picture described in this presentation. It is to be hoped that all physicians will prepare themselves to accept and to treat what the Army medical officers discovered were among their biggest problems—the emotional factors in the production of illness.

BOOK NOTICES

Textbook of Abnormal Psychology. 3rd edition. By Roy M. Dorcus and G. Wilson Shaffer. Price $4.00. Pp. 547. Baltimore, Williams & Wilkins Co., 1945.

To this book both Knight Dunlap and Ross Chapman write one-page forewords. In the one written by Doctor Dunlap he says that he is impressed with the vast amount of materials collected in this volume. So was this reviewer. Psychology, neurology, abnormal psychology, psychiatric diagnoses, and psychiatric therapy are all presented. But in nine pages of authors' index, the authors manage to exclude the names of most of the psychiatrists and psychologists with whom the reviewer is best acquainted, including Drs. Knight, Rapaport, Gill, Zilboorg, Kubie, Ebaugh, Sullivan, and others. My distant relative Menninger von Lerchenthal is, however, quoted, and Freud is cited twenty-six times, Knight Dunlap notwithstanding. (K. A. M.)

Psychoanalytic Therapy: Principles and Application. By Franz Alexander, Thomas M. French and staff members of the Institute for Psychoanalysis, Chicago. Price $5.00. Pp. 353. New York, Ronald Press Co., 1946.

The authors here present the results of their work over the past few years in attempting to apply psychoanalytic principles to what has previously been regarded as non-psychoanalytic psychotherapy. Their insistence that there is "no difference" between this and psychoanalysis is not convincing, nor is it substantiated. The discussion of some of the principles of psychoanalysis is excellent though incomplete; the case histories are of variable interest and clarity, but on the whole instructive and well presented. Just what they prove is not so clear. (K. A. M.)

People in Quandaries: The Semantics of Personal Adjustment. By Wendell Johnson. Price $3.00. Pp. 532. New York, Harper & Brothers, 1946.

Wendell Johnson has a real gift for clear exposition of a subject, General Semantics, which is either obscure or over-popularized in the hands of other writers. He has written a vitally important book, illuminated with exquisitely appropriate anecdotes and examples, making it very readable. The section on Major Maladjustments is not up to the rest of the book, but the chapter on stuttering, entitled "The Indians Have No Word For It", is an original contribution to the obscure psychiatric problem of speech disorders. All workers in the field of psychiatry will find reading this book a stimulating experience. (R. P. K.)

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